Residents as Educators Series

Engaging Medical Students in

Reflective Feedback Conversations

Karen Spear Ellinwood, PhD, JD, EdS
Director, Faculty Instructional Development

Copyright

© Karen C. Spear Ellinwood

All rights reserved
See ABOR (Arizona Board of Regents) policy on copyright of tangible materials by covered individuals.

NOTE: This iBook was created on a personally owned MacAir. All graphics are derived from Pixabay or other online resources that identified copyright via Creative Commons as either not requiring attribution, or use with attribution for commercial or non-commercial purposes, as noted. The video excerpts are used with permission of the authors Choo & Lin.

Preface

About the Author

Key Points

1. **The author** is the Director of faculty instructional development for the University of Arizona College of Medicine.

2. **The course description**, objectives and syllabus are in Section 2.

Contact Information

Karen Spear Ellinwood, PhD, JD, EdS

Director, Faculty Instructional Development
Office of Medical Student Education
Assistant Professor
Department of Obstetrics & Gynecology
The University of Arizona College of Medicine
Email:
kse@medadmin.arizona.edu

Phone: 520.626.1743

Link to CV

Biosketch

Current Positions

Administrative Professional

Director, Faculty instructional development, Office of Medical Student Education, The University of Arizona College of Medicine

Faculty Appointment

Assistant Professor, Department of Obstetrics and Gynecology, The University of Arizona College of Medicine

Professional Experience

As Director of Faculty Instructional Development, Dr. Spear Ellinwood assists clinical and non-clinical faculty, fellows and residents at the University of Arizona College of Medicine, in developing knowledge and skills in teaching and assessing medical students. She designs and implements curriculum for educator programs, and recruits other faculty and education professionals to assist in implementing curricula.

Current programs and activities include the Residents as Educators (RAE) Program, AMES/OMSE Teaching Scholars Program, AMES/OMSE Faculty Instructional Development (FID) Series, Affiliate Clinical Educators (ACE) Program and Teaching with Technology (TWT) Series.

The Teaching Scholars Program emphasizes training medical students in how to conduct education research for publication as well as for quality improvement.

The RAE Program incorporates a unique instructional development needs assessment, entailing shadowing residents as they teach medical students. The purpose is to identify teaching strengths, as well as missed opportunities for teaching, and determine relevant educational strategies and resources to support residents' educator development.

As a member of the Case-based Instruction (CBI) Team, Dr. Spear Ellinwood develops and implements facilitator training, and is assisting in the development of a new course on clinical reasoning in the undergraduate medical education program at the UA College of Medicine. She also is collaborating with the Office of Diversity and Inclusion in the formation of a new distinction track focusing on Spanish proficiency for the bilingual practice of medicine. In 2014, she created and implemented the SOS Program to support staff in enhancing their skills in using office related software. She developed nearly all the content for and manages the faculty instructional development website at http://fid.medicine.arizona.edu.

Dr. Spear Ellinwood's affiliation with the Department of Obstetrics and Gynecology provides opportunities for close collaboration on conceptualizing residents as educators activities, education research projects, and conducting or assisting with data analysis and/or publication.

Education & Background

Dr. Spear Ellinwood was born and raised in New York, and moved to Tucson, Arizona. She has lived in Tucson since December 1985.

She earned her JD from Brooklyn Law School in 1986, and was admitted to practice in the State of Arizona and the Federal District of Arizona in 1987. She practiced law from 1987 to 2000, having been a trial lawyer in criminal defense for several years. She earned an Education Specialist (EdS) degree, focusing on bilingual education and biliteracy development in 2003, and a PhD in education in 2011, from The University of Arizona College of Education, Department of Teaching, Learning and Sociocultural Studies.

Scholarly Interests

Dr. Spear Ellinwood conducts research in several areas of undergraduate and graduate medical education, including:

- Medical students' metacognitive (reflective) engagement in clinical problem-solving and their development of clinical reasoning;
- Resident educator development;
- The use of web-based tools to enhance instruction and learner engagement;
- The use of technology in self-regulated learning; and
- Curriculum design.

You may find some of Dr. Spear-Ellinwood's papers and poster presentations online at Academia.edu.

Front Cover Photo Credit

Image Preface.1 Cover Photos

The photo on the cover was obtained through a Google Images search using the advanced search tool to identify images "labeled for reuse". Other images in this course were obtained through Pixabay.com, without requirement for attribution, unless otherwise noted.

How to use these course materials

Key Points

1. **If you view this document** using the iBooks app with a Mac laptop or Apple device you will be able to access all of the interactive features.
2. **iBooks allows you to** annotate this book, engage in section and chapter review questions without leaving the iBook viewer application.
3. **If you view these materials as a PDF**, you will will need to connect to external web-based content. in place of the embedded interactive features, and
4. **However you view this document** you will have access to review questions, a final assessment, and course evaluation survey.
5. **Whether you view this document as an iBook or a PDF,** you may print parts of it or in its entirety.
6. **The pre-course, post-course and final assessments** are accessed via links to the Qualtrics Survey Tool.

Section Overview

This section describes how to use the interactive features in this iBook or interactive portable document format of the CME course.

Each section overview will indicate whether there are required or options readings in addition to the text of the section.

Interactive Features

You may view this interactive document using these applications: 1) iBooks; 2) Adobe Reader or Adobe Pro; 3) iAnnotate. The following subsections provide guidance for using each of these applications.

iBooks

iBooks is a mobile app that can be installed on smart phones using Apple's iOS, Mac laptops or desktops. You also may use Adobe Extension on a PC (non Mac) desktop or laptop to view an .iba (iBooks Author) file, although interactive features will be lost.

Using iBooks you may annotate this book, create bookmarks to particular pages or sections of the book, and view interactive content within the iBook viewer (window). For example, you will be able to view and respond to section and chapter review ques-

tions and obtain immediate feedback on the accuracy of your responses, without having to connect to an external web-based survey application. You will be able to view videos within the iBook viewer or go directly to the internet.

Some images are displayed as part of galleries and clickable controls allow you to see each one within the same space in the iBook. You will be able to zoom in or out to view the images in full screen mode and read the captions.

The gallery below includes examples of some of these functions. The iBooks application also has a help section.

PDF Version Viewable With Adobe Reader, Adobe Pro & Adobe Extension

These course materials are available inPDF, which you may view using the following Adobe applications:

- Adobe Reader (free version);
- Adobe Pro; and
- iAnnotate.

Interactive features created in iBooks Author will not be available as such in the PDF version. However, comparable Adobe features have been utilized to provide similar interaction. These differences are described below.

Review Questions

Review Questions will not be embedded in an interactive module in the document. Instead, you will click a link to a web-based Qualtrics survey (used per UA site license). You will not need to login or download anything.

Pop-ups and Galleries of Images

Pop-up examples can be accessed in the PDF version by clicking on the sticky note icons. Access Galleries of images by clicking on the paperclip icon, which opens an attachment that included in this PDF version of the course.

Videos

In this PDF version, you can view videos by clicking on the PLAY button. The video will open the video in your web browser at Youtube.com.

Glossary Terms

You can click on terms in the text to access definitions in the Glossary, which follow the final chapter of the course. Glossary terms have links back to the place in the text where the terms appear as well as a button that opens the advanced search function in Adobe Pro and Adobe Reader. These functions approximate the iBook version of this course.

iAnnotate

You may view PDFs on an iPad or tablets using iAnnotate, a smart app for mobile devices. The document will appear much like it would in Adobe Reader or Adobe Pro. The Adobe tools operate in the same way. This means you should have the same interactive functionality when viewing the PDF in iAnnotate as you do when viewing it it other Adobe applications.

iBooks enables the reader to take notes, highlight text and bookmark parts of the course material you think are important. You can do this using Adobe Reader, Adobe Pro and iAnnotate. Please refer to the tools menu to find out how to highlight or underline text, make comments, bookmark pages, and so on.

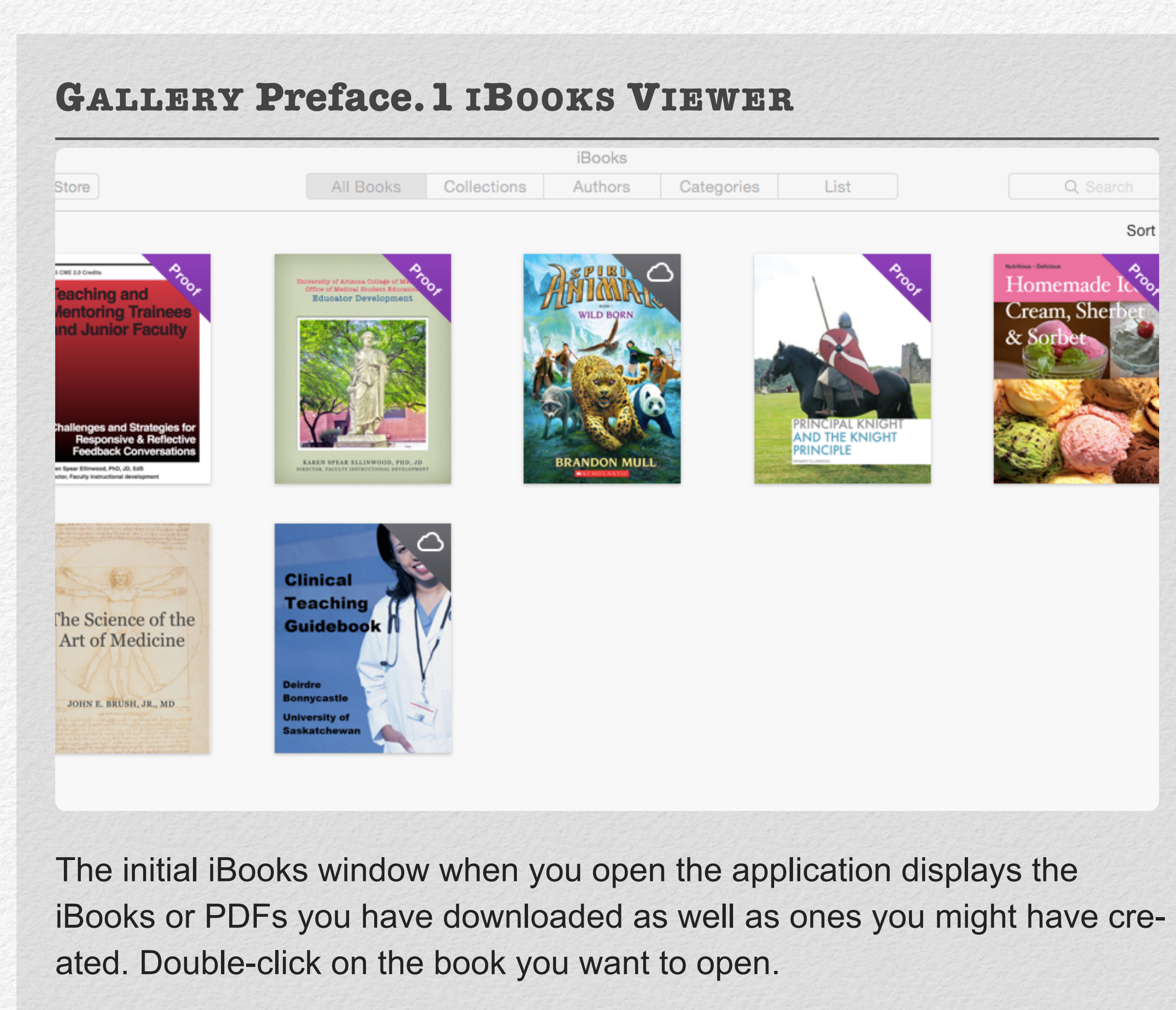
For Apple devices, you may download iAnnotate from the Apple Store. It may also be available for devices using Android operating systems or Google Play apps (link).

Need Tech Help?

If you have questions about how to use any of these applications, try using the help functions within the application first and then the help links listed below. If you cannot find the answer, please do not hesitate to contact the author.

- Help with iBooks
- Help with iAnnotate
- Help with Adobe Pro
- Help with Adobe Reader

GALLERY Preface.1 IBOOKS VIEWER



The initial iBooks window when you open the application displays the iBooks or PDFs you have downloaded as well as ones you might have created. Double-click on the book you want to open.

Click the paper clip to view the Gallery

Course Introduction

1

This chapter describes the course syllabus and objectives, the learning objectives for participants, and interactive methods of course delivery.

Residents as Educators Policy

Key Points

1. **This section describes** the policy for residents as educators development as well as purpose of the course and learning objectives for participants.
2. **The course description** addresses the purpose of the course in general.
3. **Learning objectives** establish the objectives for participation and completion of the course.
4. Section 2 contains the course syllabus, which describes the course requirements and outlines the course by chapter and section.

Section Overview

This section describes the course objectives and learning objectives for participants. It contains the course syllabus, outlining the scope of course content, activities and assessments.

Readings

- Each section will indicate whether there are required and/or suggested readings.

Residents as Educators Policy

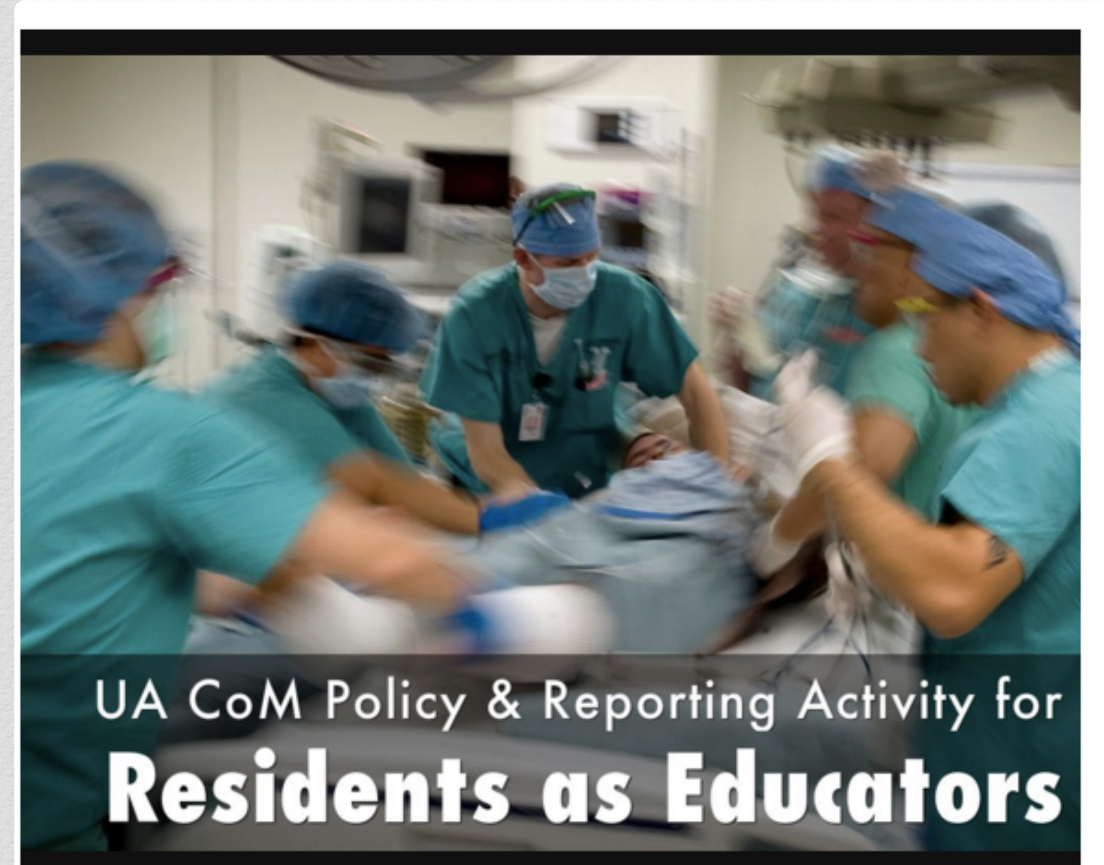
LCME requires that any residents participating in teaching medical students must participate in ongoing educator development activities (LCME Standard 9.1). The College of Medicine (UA CoM) faculty instructional development (FID) policy requires all residents who teach medical students to participate in instructional development activities.

Residents as Educators (RAE) development begins with the annual orientation for incoming interns and occurs as ongoing training during each subsequent year of residency.

Each residency program may include RAE training in different ways. Some provide their own training and integrate it with their teaching days (e.g., Pediatrics). Some invite the FID Director to shadow residents as they teach so the targeted RAE program-

ming can be created and implemented (usually as part of didactic sessions or conference days) (e.g., Psychiatry, Obstetrics and Gynecology). Still other programs work with the FID Director to collaboratively create and implement RAE activities a couple of times per year.

IMAGE 1.1 RAE POLICY GUIDE



http://fid.medicine.arizona.edu/ed-framework/policy/rae

Click the image to view the online guide to RAE Policy.

Generally, the total amount of hours spent on RAE activities per resident for each residency year is two hours. This is what the Deputy Dean for Education, Kevin Moynahan, MD, and the workgroup that generated the RAE policy recommended.

The RAE policy is part of the overall UA CoM instructional development policy and it provides as follows:

Article VI. Resident Instructional Development

Section 6.01 Orientation of residents.

Residents who teach medical students in preclinical or clinical years are expected to participate in instructional development training for a minimum of two hours at the start of their residencies.

Section 6.02 Ongoing resident instructional development.

For each subsequent year of residency, all residents are expected to complete a development session (in-person or online) focusing on teaching and assessment skills.

★Source: UA CoM Faculty Instructional Development Policy

Meet RAE Policy Requirements by Completing this Course

This course is designed to provide practical guidance for junior or senior residents in giving constructive feedback to medical students. Completion of this electronic course takes about two hours and, therefore, satisfies the annual requirement for participation in RAE development activities.

Central Monitoring & Verification of Course Completion

While this electronic course may be used individually or in small group learning situations, each participant needs to complete the final assessment to earn "credit" for meeting policy requirements. The final assessment is administered through Qualtrics survey, It will provide you with a final grade report. To ensure verification of training to the Office of Medical student Education, please be sure to include your full name, department, program and PGY status.

The Qualtrics survey tool will maintain a list of all residents who have completed the course. The FID Director will provide confirmation of completion directly to the LCME Director at the College of Medicine, and to your residency program director, if needed.

If you have questions about the policy or the process of verifying course completion, please contact the FID Director.

Relevant LCME Standards

There are several standards that informed the policy requiring residents as educators development. Below is Standard 9.1 in its entirety, along with excerpts of the proof that medical schools must provide to LCME to maintain accreditation. If you would like to know more about LCME standards and how they affect residents as educators training and policy, please see the Related Resources at the end of this section.

9.1 PREPARATION OF RESIDENT AND NON-FACULTY INSTRUCTORS

In a medical school, residents, graduate students, postdoctoral fellows, and other non-faculty instructors in the medical education program who supervise or teach medical students are familiar with the learning objectives of the course or clerkship and are prepared for their roles in teaching and assessment. The medical school provides resources to enhance residents' and non-faculty instructors' teaching and assessment skills, with central monitoring of their participation in those opportunities provided (emphasis added).

How UA CoM Prepares Residents to Teach

The Director of Instructional Development holds a Residents as Educators Orientation each year for the incoming interns. The purpose is to introduce interns to a systematic approach to teaching that promotes reflective engagement in teaching medical students.

Thereafter, residency programs and/or the Director of Instructional Development provide residents with ongoing training to prepare them for teaching medical students. The type and duration of training depends upon the department.

The minimum expectation is that residents who are teaching medical students will participate in two hours per year of educator training addressing issues of teaching and assessment.

The University of Arizona College of Medicine policy requires that such training is conducted and centrally monitored. Residency Program Directors are required to report residents as educators training to the Office of Medical Student Education. Such reports must include LCME required information: the title of the session, faculty presenters, number of hours and whether the session is required or voluntary.

Related Resources

★Download document on all relevant LCME Standards

★LCME website with links to databases for accreditation

Section 2

Course Description & Syllabus

Key Points

1. **Each chapter** contains section and/or chapter review questions.
2. **This chapter describes the course and provides a syllabus outlining the contents of each chapter.**
3. **Chapter 2** defines feedback and recommends the reflective feedback conversation model as a systematic approach to giving constructive feedback.
4. **Chapter 3** addresses the dynamics involved in giving feedback and offers strategies for addressing or avoiding common challenges in feedback situations.
5. **Chapter 4** contains surveys for self-assessment and course evaluation.
6. **Chapter 5** contains additional scholarly resources and references.
7. **A Glossary** of terms appears at the end of the book.

Section Overview

This section contains the course syllabus and a link to the pre-course self-assessment.

Course Description

Completion of this course fulfills the residents as educators (RAE) requirement for one year of educator development. The purpose of this course is to:

- Clarify commonly held misconceptions about what constitutes feedback;
- Describe the reflective feedback conversation model, a systematic approach for offering medical students and medical students constructive feedback; and
- Provide strategies for addressing or avoiding challenges in giving feedback.

Course Learning Objectives

A participant who completes this course is expected to be able to:

1. Describe the difference between evaluation and feedback as those terms are used in this course.

1. Describe the key components of the “reflective feedback conversations” approach.
2. Describe the “Feedback sandwich” and its potential limitations for delivering helpful feedback.
3. Describe strategies for addressing or avoiding challenges in feedback situations and apply these to case scenarios in the course.
4. Evaluate examples of feedback, applying the reflective feedback conversation approach.

Course Syllabus

This course is intended as a two-hour course on feedback and qualifies as meeting the UA College of Medicine policy requiring annual residents as educator training. Below is an outline of the course materials by chapter and section.

Chapter 1 - Introduction

Chapter 1 includes author information and a description of the course syllabus, objectives and learning objectives. The chapter concludes with review questions and a link to a optional pre-course self-assessment.

Chapter 2 - Deconstructing Constructive Feedback

Section 1. Distinguishing Feedback from Evaluation

This section defines feedback and distinguishes it from evaluation. It provides narrative and video examples of feedback and concludes with section review questions.

Section 2. Significant Feedback Factors

This section describes the factors identified by research as statistically significant in determining whether feedback is helpful (constructive) or not. It provides a summary of several principles of feedback that define feedback as constructive and formative to help guide resident educators toward promoting reflective practice. These seven principles are gleaned from Nicol & McFarlane-Dick’s review of research on feedback in a variety of educational settings, and are consistent with the reflective feedback conversation model suggested in the Section 4. In addition to these principles, this section concludes with a consideration of factors that can influence the course and outcome of the feedback process.

This section concludes with a list of UA CoM resources.

Chapter 3. Reflective Feedback Conversations

This Chapter describes the reflective feedback conversation model and explains why this course recommends it for communicating both face-to-face and narrative feedback.

Section 1. The Reflective Feedback Conversation Model

This section describes each component of the reflective feedback conversation model in detail. It also highlights the value of reflective engagement in learning and clinical practice, with an overview of the literature.

Section 2. Why not the Feedback Sandwich?

This section offers a summary of the popular feedback sandwich model, and its limitations in the feedback process. It also describes the microskills for teaching approach, highlighting its reinforcement of the importance of giving feedback to students in clinical teaching.

The section concludes with a summary review and review questions.

Section 3. Concept Review

The final section also includes the following:

- Section Review Questions
- Activity: Apply the concept of reflective feedback conversations to video of feedback conversation

Chapter 4 - Strategies For Challenging Dynamics

Section 1. Strategies for Challenging Dynamics

This section describes commonly encountered challenges in offering feedback to medical students and describes the following three strategies for addressing them:

- Re-establish or Clarify Expectations for Performance;
- Translate the Accusatory YOU to I/We/It Statements; and
- Use inquiry to promote reflection on performance.

Each strategy is illustrated by multiple examples.

This section also offers additional feedback “pearls”, resources and a video example of feedback in a clinical setting.

Section 2. Feedback Practice

This section offers an opportunity to apply the reflective feedback conversation model and above mentioned strategies to a clinical teaching scenario, accompanied by several questions for consideration. This scenario is divided into three segments: Background; Patient encounter; and Case presentation. Each segment is followed by an analysis that describes feedback that could be given and explains how the model and strategies could be applied. The aim is to prepare you for the course exam.

Chapter 5 - Course Exam & Evaluation

Chapter 5 concludes the course with a final examination and course evaluation. Completion of the exam is required to qualify for meeting the College of Medicine RAE requirements described in Chapter 1, Section 1.

Note

The final examination aims to assess comprehension, application and analysis of the key concepts in the course. It is administered through the web-based Qualtrics survey tool. The first section asks participant for identifying information, which confirms course completion and fulfillment of RAE requirements. You will also receive an instantaneous score.

Course Evaluation & Feedback.

The course evaluation is also administered through the web-based Qualtrics survey tool, and should take no more than 5-10 minutes to complete.

Chapter 6 - Resources And References

Section 1. References

This section contains references to scholarly, peer reviewed articles and other reputable references on the topic of feedback and evaluation in medical education.

Section 2. Resources

This section contains additional resources for learning more about feedback and strategies for incorporating feedback in the teaching/learning process.

Glossary

This document contains a **Glossary** defining key terms and concepts used throughout the book.

A Note to Residency Program Directors on How You Can Use this Course

There are various ways to use this material. One way is to simply assign the material to residents to read through and do the exercises and assessments on their own as self-directed learning.

However, you could enhance the learning experience by using these course materials as the basis for face to face sessions on feedback. Such an approach would utilize certain chapters of this course as flipped classroom materials and scenarios for review in facilitated sessions among residents.

Suggestions For Using These Materials

1. Flipped Classroom Materials

1.1. Ask residents to read Chapters 2 and 3 to help residents prepare for a face to face session with you or another experienced educator.

1.2. These chapters describe feedback concepts and the model suggested and amounts to about an hour of self-directed learning.

2. Facilitated Session.

2.1. Use the scenarios or examples in the chapters to promote discussion and application of concepts.

2.2. Residents could discuss or role-play the scenarios to practice giving and receiving feedback.

2.3. Debrief on residents' discussions or role play to Identify challenges and strategies in the feedback process.

Thank you

Thank you for participating in this Residents as Educators course. I hope it is helpful to your educational practice and look forward to your feedback on the course.

The Backstory on Feedback

This chapter defines feedback as the term is used in this course, distinguishing it from *evaluation,* and describes various feedback models. It recommends the reflective feedback conversation model as a systematic approach to giving constructive feedback to medical students. This chapter also contains section review questions, interactive activities and a chapter recap.

Is it Feedback or Evaluation?

Key Points

1. **Evaluation** tells the medical student whether they performed well or poorly.
2. **Evaluation** helps the medical student understand the quality of their performance according to educational or professional standards.
3. **Feedback** tells the medical student why the evaluator concluded that the performance was good or poor.
4. **Feedback** helps the medical student to understand not only WHAT they need to improve but WHY.
5. **Constructive feedback** should offer guidance as to HOW the medical student can improve performance.

Section Overview

This section defines and distinguishes the concepts of feedback and evaluation, and contains section review questions.

Required Readings

- Please read this section, watch the video excerpt (link provided in text), and complete the review questions.

Why feedback?

Educators offer feedback to learners to help them improve "knowledge and skill acquisition," as well as motivate learning (Schute, 2008). Thus, to be effective, feedback should always be constructive (helpful) and, therefore, formative.

What is evaluation?

Evaluation tells the medical student whether they performed well or poorly, or somewhere in between. Effective evaluation should help the medical student understand the quality of their performance as judged by some agreed upon professional or academic standard.

Often educators intend for their statements to serve as feedback, but the statements are more accurately characterized as evaluation. The examples below are common statements by clinicians,

whether attendings or residents, in response to student performance. While these might communicate some sense of the quality of the performance, none of these tells the learner anything about WHY the performance was considered good or in need of improvement.

Examples

•Great job!	•Enthusiastic, upbeat!
•Very good follow through	•Fun to work with
•Good with patients	•Poor fund of knowledge
•Excellent attitude	•Needs some guidance
•Had a very good shift	•May improve over time

Source: Giving Effective Feedback: Beyond Great Job. ALiEM Educational Videos. http://youtu.be/DbfISZjG9mU.

So what *is* Feedback?

Feedback tells the medical student *how* they performed and why their performance is considered good, poor or otherwise. In other words, feedback offers the factual basis and the instructor's rationale for their evaluation of the student's performance. Feedback, then, should be constructive whenever it is given.

> *[F]eedback is formative, meaning that it happens in real time with the intent of helping the learner develop and improve. Feedback is designed to foster learning. Feedback is about current, rather than past, performance. It is meant to convey information, reinforce strengths, and identify areas in need of improvement, "before it counts." (Kogan 2013, 92).*

This means that feedback describes ***relevant, observable behaviors***, and explains why these constitute adequate performance (or not). Feedback includes, as well, insight as to HOW to improve performance. Below is an example:

> I liked that you were able to use medical images on your tablet to demonstrate the uptake of insulin to help Mrs. Johansen to understand the diabetes disease process and progression, and explain why we need her to follow the plan of care. A few times you used technical terms like "uptake", which seemed to confuse her. When you translated those to lay terms, she seemed to be able to to participate in the discussion more than she had on prior visits.

Why is it helpful to distinguish feedback from evaluation?

No matter who the learner is, the value of feedback lies in encouraging the continuation of successful behaviors and guiding improvement of knowledge and practice. Distinguishing feedback from evaluation is an important part of this process. Comments such as "good job" or "try to do better next time" - without more, offer no guidance whatsoever.

A medical student might spend only one shift with you. They might participate in several patient encounters during the course

of that shift and perform a variety of tasks. They might present cases to you, or to the attending directly. They might perform the history and physical or participate in a consult with another service.

No matter how long or short your exposure, each interaction offers an opportunity to teach by giving feedback. Consider the scenario below.

Scenario

Jamie is a third year medical student in the Family and Community Medicine clerkship. You have asked her to do the knee exam on a returning patient who injured his knee playing soccer a few weeks ago. The patient has since had physical therapy four times, as you had directed.

This is Jamie's first encounter with this patient. She has never performed a knee exam on her own. You ask her if she feels confident in doing it while you observe. She says she does. As Jamie performs the exam she feels for warmth, looks for redness and inflammation and listens for aberrant sounds in the knee joint. But you notice she only performs a "passive" exam and does not ask the patient to move the knee on his own to examine for muscle strength. This is something you would have done. Especially following a course of treatment, you would want to see if the patient has been able to restore his former functionality of the knee and surrounding musculature.

You then conduct an active knee exam with this patient while Jamie observes.

Then, you and Jamie see 3 more patients. During those encounters, Jamie advises one patient on how to use her inhalers for chronic asthma, listens for heart sounds on another who reported feeling palpitations, and interviews a 13yo female who reports irregularities in her menstrual cycle.

At the end of the day, you are about to write your patient notes and tell the medical student:

"You did a good job today. There are some things you could improve, but overall you should be feeling pretty good right now. I've got to do my notes, but let me know if you have any questions."

Jamie does not ask any questions.

Analysis

In this scenario, telling Jamie she did pretty well but needs *improvement* failed to convey any useful or helpful information. In other words, the so-called feedback was merely evaluative (good job/bad job) with no description of specific, observable behaviors to anchor the comments.

Without an *explanation the* medical student has no idea which aspect of their performance qualifies as good performance or is in need of improvement. Jamie needed advice on how to conduct an active knee exam. The student could have benefitted as well

from an explanation as to why a physician would want to do an active knee exam in this particular case.

Even if Jamie's performance in subsequent patient encounters went well, the resident should offer feedback on interviewing and communication skills, or medical knowledge to reinforce positive behaviors.

> **Bottomline**
>
> Distinguishing feedback from evaluation reminds us that we need to say more than just good job or needs improvement.

What makes Feedback Constructive?

Constructive feedback is helpful feedback. Hewson and Little (1998) identified statistically significant factors supporting the categorization of feedback as helpful or unhelpful. They concluded that, to be helpful (constructive), the feedback process should include:

- A description of relevant, observable behaviors;
- An invitation for the learner to self-assess performance;
- Positive reinforcement;
- Correction; and
- Guidance to help the learner improve.

According to Hewson and Little (1998), feedback is constructive if it is perceived as *helpful* to the medical student in understanding the nature of and how to improve their performance. Hewson and Little gathered qualitative data from educators and medical students at several institutions to identify helpful and unhelpful factors in the feedback process.

Thus, truly constructive feedback seeks to encourage the student's receptivity to feedback. Ende (1983) stated:

> *Anything that helps the medical student see feedback for what it really is—an informed, nonevaluative, objective appraisal of performance intended to improve clinical skills—rather than as an estimate of a medical student's per- sonal worth will help the process.*

> **Bottomline**
>
> Constructive feedback engages the learner in a conversation about performance in relation to established expectations, and, as appropriate, to their long-term goals. Treating feedback as a conversation rather than a one-way transmission communicates that you want the learner to participate actively in the process and will consider their perspective.

Activity: Is this feedback or evaluation?

Please click this link to watch a video example* of an interaction between a learner and attending. The excerpt will begin at **5:49** minutes and is approximately 40 seconds long.

Think About…

- The types of comments the attending physician offers to the medical student.
- Which statements would you characterize as *evaluation*?
- Which would you characterize as *feedback*?

Review Questions

After reviewing the video, you may review the section review questions to review key concepts in this section.

★**For PDF viewers: Click this link for the Review Questions.**

Movie 2.1 Is this feedback?

Source; Choo E & Lin M. Giving Effective feedback in the Emergency Department. San Francisco General hospital Department of Emergency Medicine. UCSF and SFGH; 2007 (Used here with permission of the authors, March 4, 2015; copyrighted material available on YouTube, https://www.youtube.com/watch?v=DbfISZjG9mU#t=349).

Press the PLAY icon at right to view the video segment.

Review 2.1 Section Review Questions

★ **For PDF viewers: Click this link for the Review Questions.**

References

Video Source

Lin M & Choo E. Giving Effective Feedback: Beyond Great Job. AL-iEM Educational Videos. http://youtu.be/DbfISZjG9mU; 2011.

*This faculty development video was developed by Dr. Esther Choo and Michelle Lin, MD, for the University of California San Francisco College of Medicine, and may be accessed at YouTube.com and ALiEM (Academic Life in Emergency Medicine) by clicking on these links: YouTube or ALiEM.

Significant Feedback Factors

Key Points

1. **Several statistically significant factors** define feedback as helpful.
2. **Helpful feedback invites self-assessment** or reflection on learning and practice.
3. **Helpful feedback is anchored to established expectations** per academic or professional guidelines.
4. **Helpful feedback describes relevant, observable behaviors** to offer a factual basis for both reinforcing and corrective feedback.
5. **Helpful feedback includes actionable guidance, t**hat is, suggestions upon which the student take action to improve.
6. **Several principles of formative feedback** are aligned with these factors and the model recommended by this course.

Section Overview

This section contains a description of the factors that Hewson & Little's (1998) study found to be statistically significant in determining whether feedback is helpful (constructive).

Significant Feedback Factors

There are several attributes of the feedback process that have been found to be statistically significant in recipients perceiving feedback as constructive or helpful (Hewson & Little, 1998). These factors are described below and also form the foundation for the feedback model this course recommends (*see* Chapter 3).

1) Description Of Relevant, Observable Behaviors

This term refers to **specific examples of behavior**, statements, demonstrated knowledge or practices that can be observed, and not to the inferences that one might draw from such observations.

2) Invitation To Self-assess Performance

This term refers to any statement or request that elicits from the medical student their **reflection on performance**, whether it concerns a specific event or addresses their progress over time.

3) Positive Reinforcement

This term refers to **affirmations of behavior**, statements or practices that were within or beyond established expectations for performance.

4)Correction

This term refers to comments that inform the medical student about specific behaviors, knowledge or practices that do not fall within established expectations for medical students.

5) Guidance

Guidance refers to **advice for improvement,** to include facilitating the learner's discussion of suggestions for changes that would improve performance. Guidance also may include modeling the correct behavior, skill or practice.

6) Anchor Feedback To Established Standards Or Expectations

Educators may "maximize the effectiveness of self-assessment by defining explicit learning targets," (Chan et al. 2014). **Learning targets** may be objectives for a particular endeavor or the broader longitudinal goals a resident or medical students seek to achieve.

We can also characterize "learning targets" as expectations for performance or learning objectives.

We ought to measure medical students' performance by what we expect them to know or be able to do in a given context and a particular point in their medical education program.

Think of the ACGME Milestones for residents. You would not want your program director to expect you to perform at the level of responsibility expected of a PGY3 when you were an intern.

It is the same with medical students. All medical schools establish expectations for medical student performance. For example, the UA College of Medicine has a list of **educational program objectives** (EPOs) that describe what medical students should know and be able to demonstrate by the time they graduate. EPOs establish a standard of behaviors, medical knowledge for academic and procedural competence.

To anchor feedback to expectations, then, we must set or refer to reasonable expectations for medical student performance. The EPOs and other institutional resources are listed and linked below.

Profession-wide Standards or Guidelines

You may also refer to profession-wide standards for performance. For example, when teaching fourth year students (MS4), you could discuss with them ACGME Core EPAs. Core EPAs provide a baseline expectation for performance by incoming interns in resi-

dency. While the Core EPAs do not apply to medical student performance directly, they could serve as the long-term goals for areas of competence they should achieve by the time they graduate.

7 Principles of Good Feedback Practice

In addition to the research identifying statistically significant attributes of "helpful" feedback, Nicol & McFarlane-Dick (2006) proposed seven principles of "good feedback practice" based upon a review of research on feedback in higher education settings. They suggest that "good feedback practice":

1. Helps clarify what good performance is (goals, criteria, expected standards);
2. Facilitates the development of self-assessment (reflection) in learning;
3. Delivers high quality information to students about their learning;
4. Encourages teacher and peer dialogue around learning;
5. Encourages positive motivational beliefs and self-esteem;
6. Provides opportunities to close the gap between current and desired performance;
7. Provides information to teachers that can be used to help shape teaching.

(Nicol & McFarlane-Dick, p. 206).

Influential Factors to Consider

In addition to the seven principles of feedback, we should consider other factors which might influence the success of the feedback process.

For example, whether the observed patient encounter involved high risk (e.g., possible sepsis; heart attack; gestational diabetes) can affect the medical student's and your emotional investment in the process and outcome of patient care, and, therefore, the feedback you elect to offer and the learner's receptivity. You might not know the student. Perhaps, you just met today, but it's necessary for you to give some critical feedback that this or any student might feel is "negative". How would you give critical feedback to someone you don't know? Does that make it easier? More challenging?

Awareness of such **influential factors** that could affect the course and outcome of the feedback process is the first step to considering how to address them.

The following are some **influential factors** in the feedback process:

- **Communication skills** - the respective communication skills and styles of the instructor and learner;
- **Context** - the context or situation surrounding the student's behavior, patient encounter or other circumstance (including the interests at stake for the student, resident educator, patient or others);
- **Delivery** - manner and tone of delivery.
- **Hierarchy** - the participants' relative hierarchical position as well as the instructor's hierarchical position (is this someone from whom this medical student will accept critical feedback);
- **History** - Relationship between the resident educator and the medical student, including their interpersonal dynamics and shared history or lack thereof;
- **Receptivity** of the participants to corrective remarks; and
- **Timing** - for example, is it proximal to the event.

Engaging in face-to-face communication requires awareness of self and other. It involves dynamics of interpersonal communication. When giving feedback, then, it also helps to consider the following:

- The participants' expectations for the conversation;
- Whether the participants abide by those expectations during the encounter;
- Whether participants address any perceived violations of those expectations;
- The participants' role in the broader context or group (e.g., residency program, department; division); and
- Any other factors that would tend to affect the position, power or authority to speak or address issues of performance or the relationship itself.

Summary

Effective teaching means we establish expectations for medical students and confirm their understanding *before* offering feedback. It also means we anchor feedback to these expectations. Helpful feedback includes a description of relevant, observable behaviors that supports both critical (corrective) and complimentary comments. Helpful feedback includes actionable guid-

ance, that is, guidance based on observable behaviors and anchored to established expectations.

The Reflective Feedback Conversation model, introduced in the next chapter, is well-aligned with these seven principles of "good feedback practice" and incorporates the statistically significant attributes identified by Hewson & Little (1998).Review Questions

Please answer the section review questions to help you recall key concepts described in this section.

Review 2.2

★**For PDF viewers:** Click this link for the Review Questions.

UA CoM Resources

To determine what to expect of medical students, residents should refer to the following resources:

- General Clerkship Manual
- **Clerkship Coordinators** can provide you with an electronic copy of the clerkship manual for the specific clerkship in which you teach, e.g., Pediatrics, OB/Gyn.
- **Clerkship Directors** can clarify learning objectives they would like for you to emphasize in your interaction with medical students.
- **The Office of Medical Student Education** can also provide the following support...
  - Director of Faculty Instructional Development for Residents as Educators instruction, materials or related activities (Karen Spear Ellinwood, PhD, JD, EdS);
  - Program Manager for Clinical Years (Diane Poskus, MA) for information about general clerkship policies and curriculum;
  - Manager of Curriculum & Assessment (Susan Ellis, MA, EdS) for information or instruction on assessment of student performance in clerkship; and
  - Director of Resident & Fellow Development (T. Gail Pritchard, PhD) for assistance with improving communication skills.

Reflective Feedback Conversations

Section 1 of this chapter describes the reflective feedback conversation model recommended by this course, and scenarios for you to practice applying this model. Section 2 discusses the "feedback sandwich" model and its limitations. Section 3 offers a review of key concepts.

Reflective Feedback Conversations

Key Points

1. **The Reflective Feedback Conversation model** incorporates Nicol & McFarlane's (2006) seven principles of "good feedback practice".

2. **The Reflective Feedback Conversation model** frames feedback as on ongoing conversation.

3. **The Reflective Feedback Conversation model** asks educators to convey specific descriptions of relevant observable behaviors to support both complimentary and critical comments.

4. **The primary goal of this approach** is to promote improvement through the learner's and educator's reflective and interactive engagement in the feedback process.

Section Overview

This section describes a systematic approach to teaching through constructive feedback called the reflective feedback conversation (Cantillon & Sargent, 2008).

Readings

Please read the brief article by Cantillon and Sargent (2008) describing what they call the reflective feedback conversation.

Of the optional readings, Hewson and Little (1998), identifies several statistically significant factors that influence the effectiveness of feedback in medical education. Goodyear (2014) provides a salient review of feedback literature and argues the need for a reflective approach to giving feedback as a method of teaching clinicians.

What is a reflective feedback conversation?

The concept of a "reflective feedback conversation" reframes feedback as a conversation between resident educator and learner, eliminates the need for prioritizing the sequence of critical and positive feedback, and "places greater emphasis on the learner's own ability to recognise performance deficits and includes a discus sion about how the learner plans to improve,"

(Cantillon & Sargeant 2008, 1294). The model embodies the seven principles of what makes feedback constructive (helpful) discussed in the previous section (also, Nicol & McFarlane-Dick, 2006). The key to applying this model is reflective and interactive engagement in the feedback process.

Why do educators care about reflection?

Reflection is contemplative and implies an intention to learn from practice or experience. Professional practice requires self-regulation, which necessitates reflection on self, others and circumstances (Goodyear, 2014). In addition to Schön's (1983) and subsequent studies on the value of reflection in professional practice, the academic literature defining self-regulated learning also affirms the value of engaging in reflective practice.

Reflection And Self-regulated Learning

Professional practice is a process of **self-regulated, evidence-based decision making** (Schön, 1983). Self-regulation involves assessment, planning, implementation, monitoring, and evaluation (see, Kaplan & Berman, 2010; Rager, 2006). These processes entail reflection on self and practice and are integral to the reflective feedback conversation model recommended here.

For example, a professional assesses what a particular situation requires of them, and whether their present abilities will meet those demands, or whether additional training or knowledge is necessary. During planning, the professional considers their assessment of self and situation, and identifies the funds of knowledge available in their community of practice to which they belong (including peers and supervising clinicians), and other relevant resources. The professional also decides whether to take action, what action to take and how it should be taken.

How the professional implements a plan of action represents their application of knowledge, skills and practices.

At the conclusion of an experience, the professional evaluates the outcome and how they achieved (or failed to achieve) their goal, or how they might approach the situation more effectively and/or efficiently next time.

Medical are novices in clinical practice. Your professional guidance is necessary to help them recognize when they might be committing error or need to review the situation and reconsider their decisions.

The resident educator's role, then, is to scaffold the medical student's ability to engage in self-regulated learning so they can:

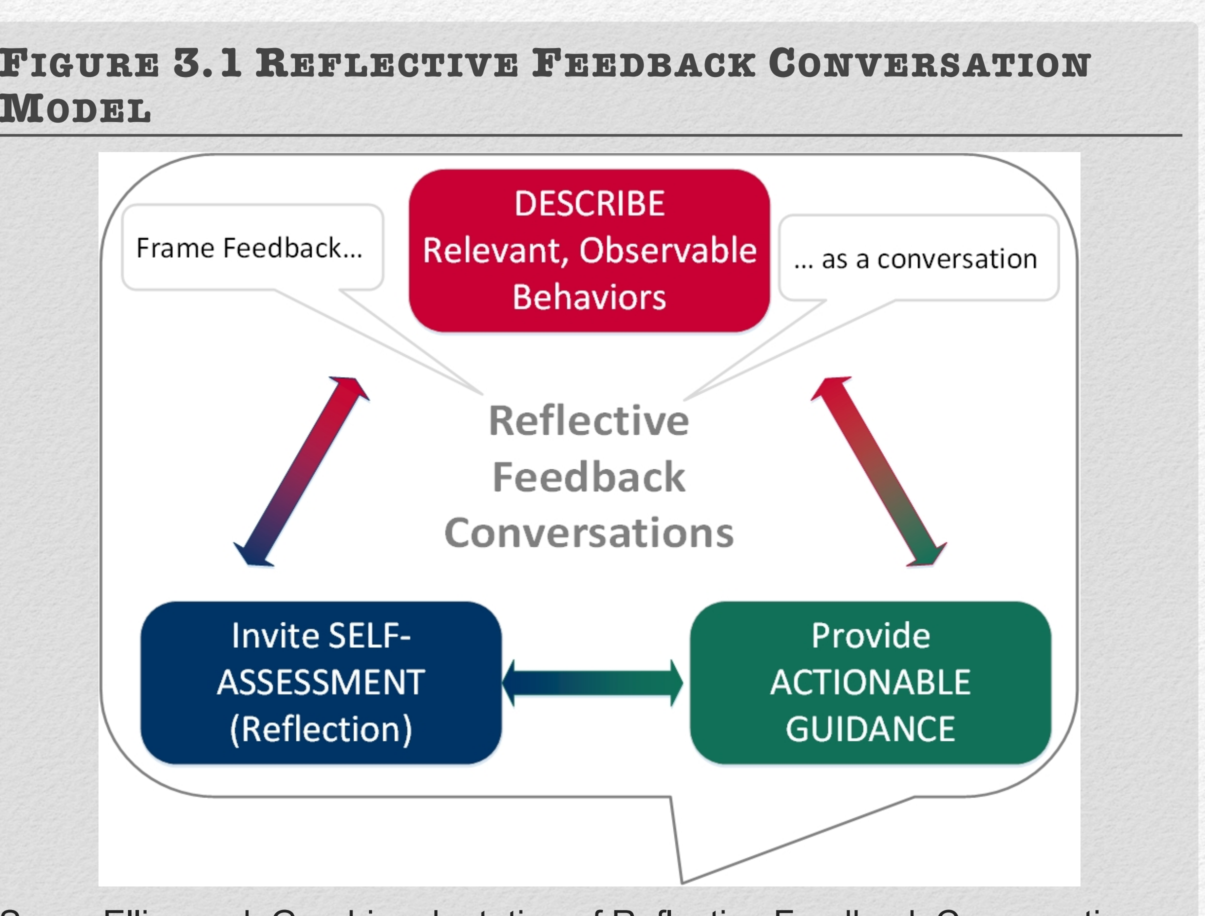
> *(1) gradually transfer[] responsibility to the supervisee and (2) gradually remov[e] support. Both strategies concern customizing the learning experience to the capabilities of the particular supervisee. (Goodyear 2014, 91).*

Scaffolding involves shifting one's pedagogy from direct instruction (telling the learner what they need to know and how to do it) toward **actionable guidance**. In other words, the learner must move from instructor-dependent learning toward self-regulated learning. Engaging the learner in a dynamic and formative feedback process is a strategy for scaffolding self-regulated learning and practice (Goodyear, 2014).

The *reflective feedback conversation* model, suggested by Cantillon and Sargeant (2008), is a systematic approach to scaffolding this self-regulated learning process. It entails the medical student's reflection in and on professional growth and practice by structuring feedback as a conversation involving the resident educator's and medical student's collaborative evidence-based assessment of practice. The goal is to offer recommendations for and encourage the medical student's active participation and investment in their professional improvement.

Figure 3.1, below, is a graphic interpretation of the essential components of a reflective feedback conversation. The graphic, like the model, does not specify a sequence for positive reinforcement and correction. Rather it suggests these components should be included in the conversation to merit qualification as constructive or helpful feedback. The order of constructive correction and compliments is determined by many factors, including the relationship between the resident educator and medical student. These factors are discussed in more detail in Chapter 4.

Figure 3.1 Reflective Feedback Conversation Model



Spear-Ellinwood. Graphic adaptation of Reflective Feedback Conversation model by Cantillon & Sargeant (2008). Click image to enlarge.

Components of the Reflective Feedback Conversation

The components of the reflective feedback conversation model are described in more detail below.

Invite Self-assessment

The underlying pedagogical force at work in this model is the concept that reflection on performance has the potential to identify error and avoid mistakes in future performance (Schön, 1983; also Plack & Santasier, 2004).

> *"Feedback is fundamental to effective clinical teaching and supervision of medical students."*
>
> *"The reflective feedback conversation approach encourages the development of the medical students' ability to self assess and leads to a shared view of what the agreed improvements will look like." (Cantillon & Sargeant 2008, 1294).*

Therefore, it is important to invite self-assessment. In some situations, it might be more productive to ask the medical student for their perspective on the encounter *before* giving feedback. This will let you know if the student shares your concerns, whether they demonstrate an awareness or lack thereof of the behaviors you have identified as concerning or understand the expectations you had for their performance.

When you discover a gap in understanding or expectations, you can ask the medical student to explain how they arrived at their understanding or to explain why they perceived the event in that way.

In many instances, it will help the student for your to describe the specific event that triggered the feedback conversation. The description will offer the medical student a point of reference for the conversation. Without it, an invitation for self-assessment such as, *how do you think you did today?*, might well be too vague and leave the student wondering what they should address or say.

The invitation to self-assess also should not operate as a mere exercise in self-reflection. Therefore, the educator should acknowledge and respond to the medical student's self-assessment as they convey their assessment and feedback (Kogan, 2013). This acknowledgement can also reinforce the medical student's active participation in the reflective feedback conversation and encourage engagement in reflective practice.

Benefits of self-assessment

- Establishes common ground for the resident educator and medical student.

- Gives the medical student an opportunity to reflect on performance.
- Clarifies mutual expectations for performance.
- Identifies possible error or gaps in the resident educator's and medical student's assessment of performance.
- Enables the resident educator to assess the medical student's awareness, attentiveness to expectations and other circumstances affecting performance.

Examples of how to invite self-assessment

To foster self-assessment and promote reflection, you may ask the medical student to review the given set of events and,

- Identify at least one behavior or skill they performed well and one thing they could have done better or that caused them concern or a lack of confidence.
- Describe challenges they faced in a given situation or particular rotation.
- Articulate how they have attempted to address those challenges.
- Identify difficulties encountered in attempting to overcome those challenges.
- Explain the progress they have made since the last conversation or in a given situation or with respect to specific behaviors identified as problematic or concerning.

Bottomline

Inviting self assessment tells you about the challenges the learner faces, and the extent to which the medical student is aware of their own performance (including mistakes) and how they might sustain or improve it.

Describe Relevant Observable Behaviors

This feedback model requires instructors to provide or elicit from the learner a **description of specific, relevant observable behaviors** to contextualize feedback.

Providing evidence of the behavior will help the learner to know the specific behavior they should continue or need to improve. It will also help the educator determine whether they share the same understanding of expectations for performance or characterization of whether performance meets those expectations.

In other words, use the feedback conversation to clarify and identify any gaps in understanding.

The conversation also enables the medical student to correct any misconceptions there might be about their performance, attitudes or behaviors observed.

Click on the images below to compare the two versions.

Which version offers *sufficient detail to enable the medical student to act upon the feedback*?

Analysis

Version 1 uses evaluative remarks (opinion) to characterize aspects of the medical student's conversation with the patient's husband that the educator thought were either positive or in need of improvement.

Version 2 supplements these evaluative remarks with specific examples of relevant, observable behaviors.

Offer both constructive compliments and correction

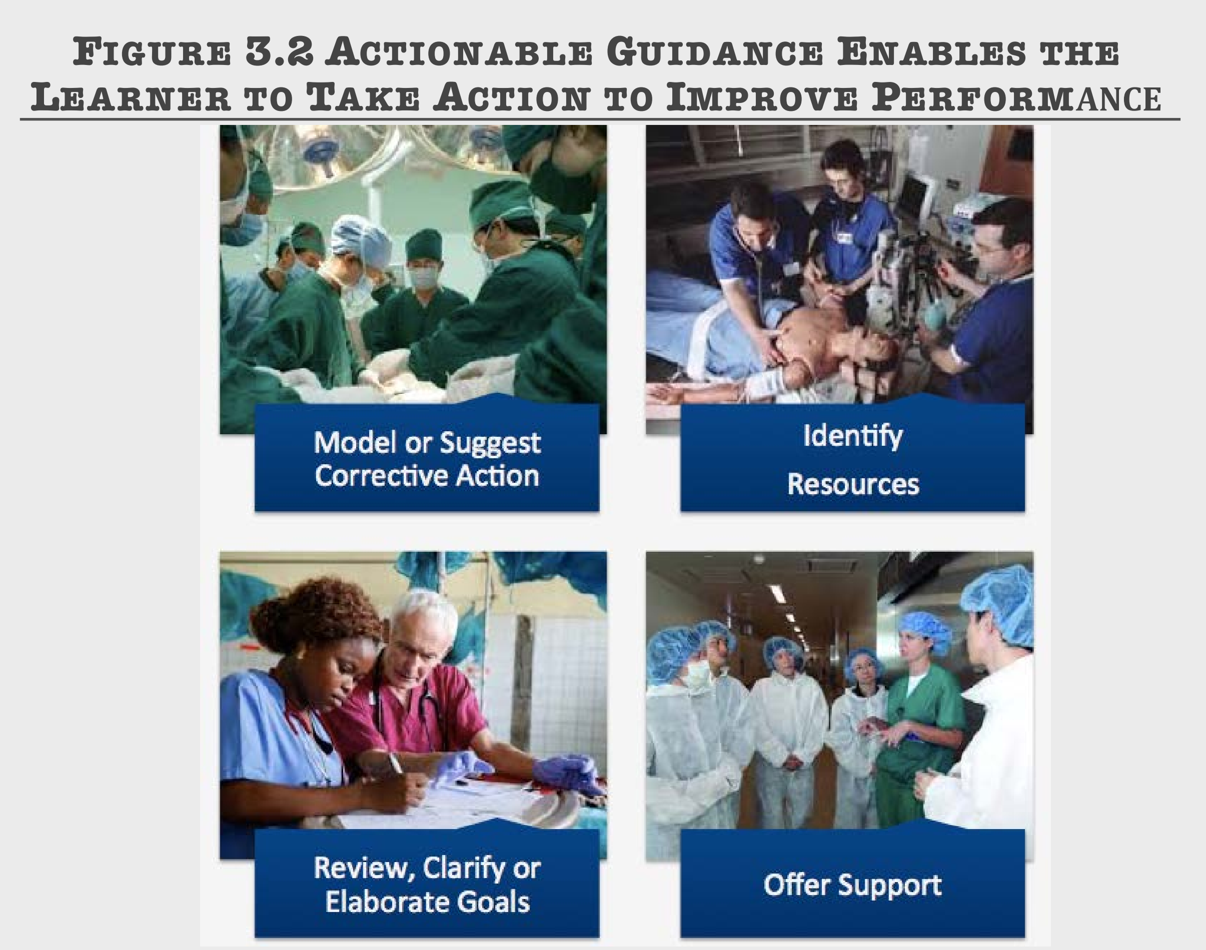
This model emphasizes that any feedback - whether positive or critical, should be constructive

How you sequence positive and critical remarks will depend upon your relationship with the medical student and/or the medical student's temperament or receptivity to critical feedback.

Provide Actionable Guidance

Actionable guidance consists of suggestions not only regarding WHAT to improve but HOW to improve. In other words, guidance must be phrased in a way that enables the medical student to act upon your suggestions.

Figure 3.2 Actionable Guidance Enables the Learner to Take Action to Improve Performance



Encourage the learner to actively participate in brainstorming actionable guidance. During the course of the feedback conversation, you could:

- Review and/or clarify goals for this clinical experience and their next clerkship or internship.
- Offer concrete resources or assistance.
- Suggest or model the appropriate conduct.
- Identify additional helpful resources.

INTERACTIVE 3.1 ANATOMY OF A REFLECTIVE FEEDBACK CONVERSATION

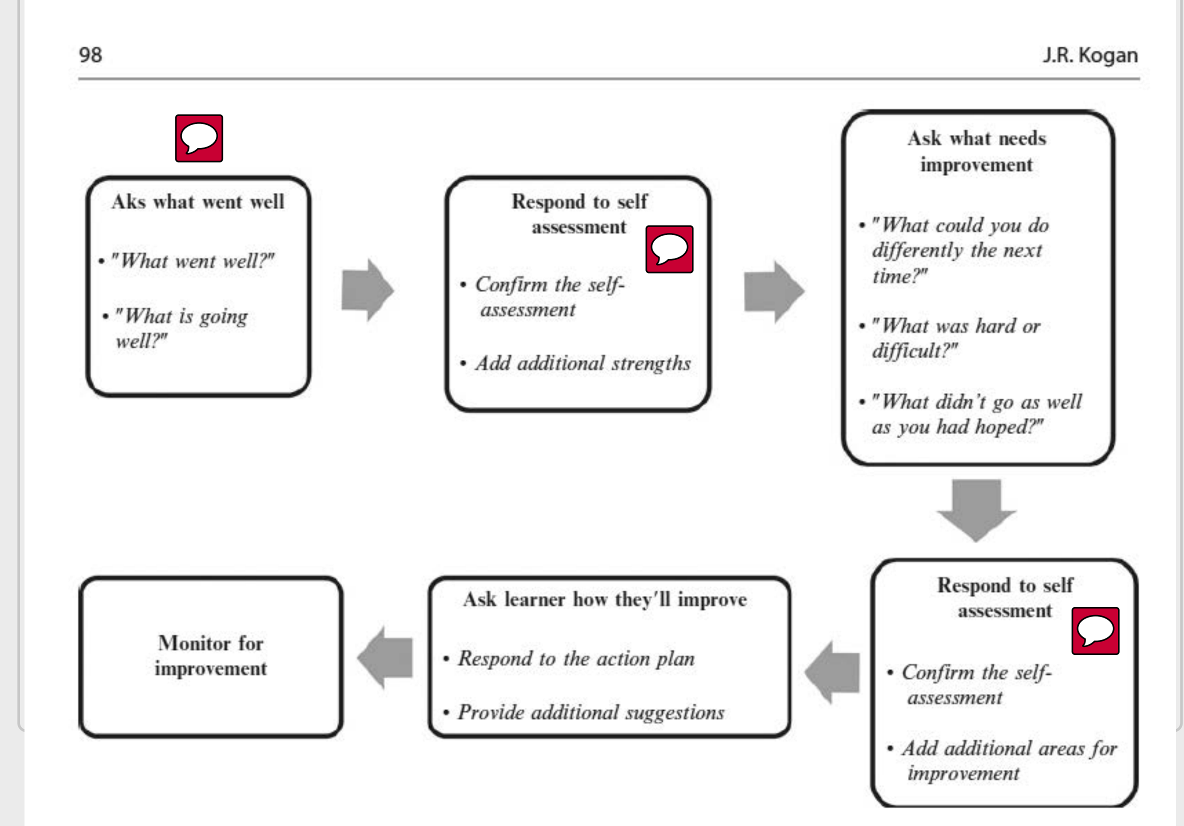


Figure source: Kogan (2013).

Summary

Feedback should include external assessment of the medical student's performance (what you, the resident educator thinks), as well as the medical student's self-assessment (see Kogan, 2013). This invites an ongoing, two-way conversation that anticipates both positive reinforcement and constructive corrective feedback. We should encourage the learner to be actively engaged in the process, and we should be responsive to the learner's ideas, opinions, and perceptions.

> *[I]n elaborative feedback encounters, the faculty member helped the resident assess and reflect upon the encounter and his or her skills. These encounters were characterised by dialogue between the faculty member and resident, and questioning by the faculty member. There was reaction and interaction. (Kogan et al. 2012, 205).*

One of the benefits of framing feedback as a conversation is the natural emphasis on being responsive to students' self-assessment. This approach can help identify gaps between your and the medical student's knowledge or perceptions.

In deciding how to sequence positive and critical feedback, the resident educator should consider the context and relationship or history shared with the medical student rather than arbitrarily deciding to sandwich critical comments in between positive ones.

In Contrast

Unlike the "feedback sandwich," reflective feedback conversations do NOT emphasize the SEQUENCE of corrective and positive feedback, and provide concrete guidance for how to offer corrective feedback (see also Kogan, 2013).

Will it take more time to use this approach to feedback?

Whether your feedback is in writing or face-to-face, describing specific examples to support your assessment of the learner takes a bit more time. Giving specific examples with feedback means more words, more forethought about the kind of feedback the learner needs. "With practice, this strategy can be done quickly and can be routinely incorporated into clinical teaching and learning" (Cantillon & Sargeant 2008, 1294).

Bottomline

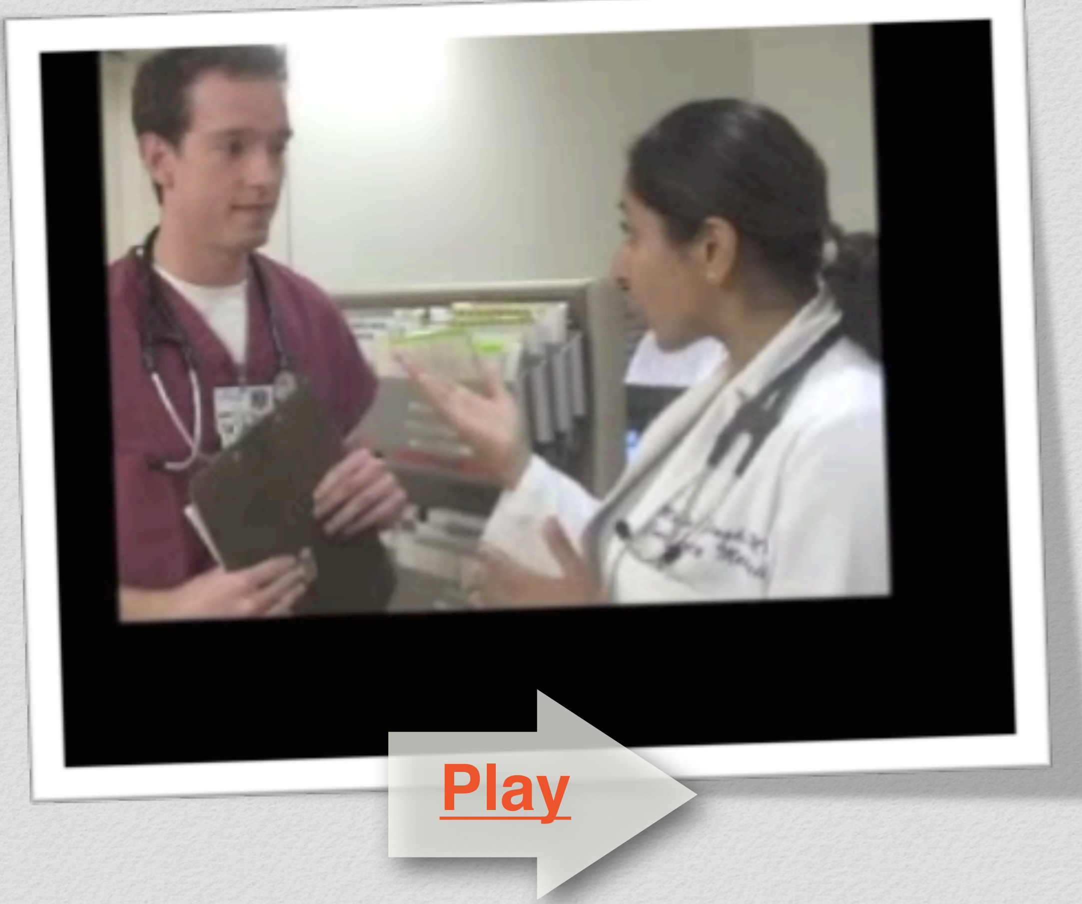
The reflective feedback conversation model reframes feedback as a conversation and emphasizes reflection as critical to improvement. Reflective feedback conversations intend to characterize the educator/learner relationship as a partnership in the medical student's professional growth.

Section Review Questions

Please review the video and answer the section review questions.

★**PDF viewers:** Click this Link to access Review Questions

Movie 3.1 Feedback Example



Watch this video excerpt and answer the Section Review Questions. Source; Choo E & Lin M. Giving Effective feedback in the Emergency Department. San Francisco General hospital Department of Emergency Medicine. UCSF and SFGH; 2007 (Used here with permission of the authors, March 4, 2015; copyrighted material available on YouTube, https://www.youtube.com/watch?v=DbfISZjG9mU#t=439

Review 3.1 Reflective Feedback Conversations

★**PDF viewers:** Click this Link to access Review Questions

References

[Click on the hyperlink to the year in each reference to access the respective publishers' FREE pdf of the articles.]

Cantillon P & Sargeant J. Giving Feedback in clinical settings. *British Medical Journal 337*:1292-94; Nov 2008.

Rodney K. Goodyear (2014) Supervision As Pedagogy: Attending to Its Essential Instructional and Learning Processes, The Clinical Supervisor, 33:1, 82-99, DOI: 10.1080/07325223.2014.918914

Optional Readings

Goodyear RK. Supervision As Pedagogy: Attending to Its Essential Instructional and Learning Processes, The Clinical Supervisor, 33:1, 82-99; 2014.DOI: 10.1080/07325223.2014.918914.

Hewson MG & Little ML. Giving Feedback in Medical Education. *Journal of General Internal Medicine, 13*: 111–116; 1998. [doi: 10.1046/j.1525-1497.1998.00027.x]

Kogan JR, Conforti LN, Bernabeo EC, Durning SJ, Hauer KE & Homboe ES. Faculty staff perceptions of feedback to residents after direct observation of clinical skills. *Medical Education 46*: 201–215; 2012 [doi:10.1111/j.1365-2923.2011.04137.x]

Kogan J. How to evaluate and give feedback. In, L.W. Roberts (ed.), *The Academic Medicine Handbook: A Guide to Achievement and Fulfillment for Academic Faculty*. Springer:New York, pp. 91-101; 2013.[doi 10.1007/978-1-4614-5693-3_11]

Why not the Feedback Sandwich?

Key Points

1. **The "feedback sandwich"** is a popular model for giving feedback.
2. **The "feedback sandwich"** begins and ends with positive affirmations of the learner's performance.
3. **While the feedback sandwich** reminds educators to offer feedback, the model does not emphasize a fundamental description of relevant, observable behaviors nor reflection nor learner self-assessment.
4. **One important limitation of the feedback sandwich model is its emphasis on** positioning critical remarks in between positive reinforcement, which focuses more on saving face for the recipient of the feedback than on encouraging change in practice for improvement.

Section Overview

The academic literature has various models for giving feedback. This section describes a well known model for giving feedback that has been used in medical education: the feedback sandwich (David & Jacobs, 1985). This model emphasizes the relative positioning of positive and critical feedback rather than the importance of reflective practice as an element of the feedback process.

The Feedback Sandwich

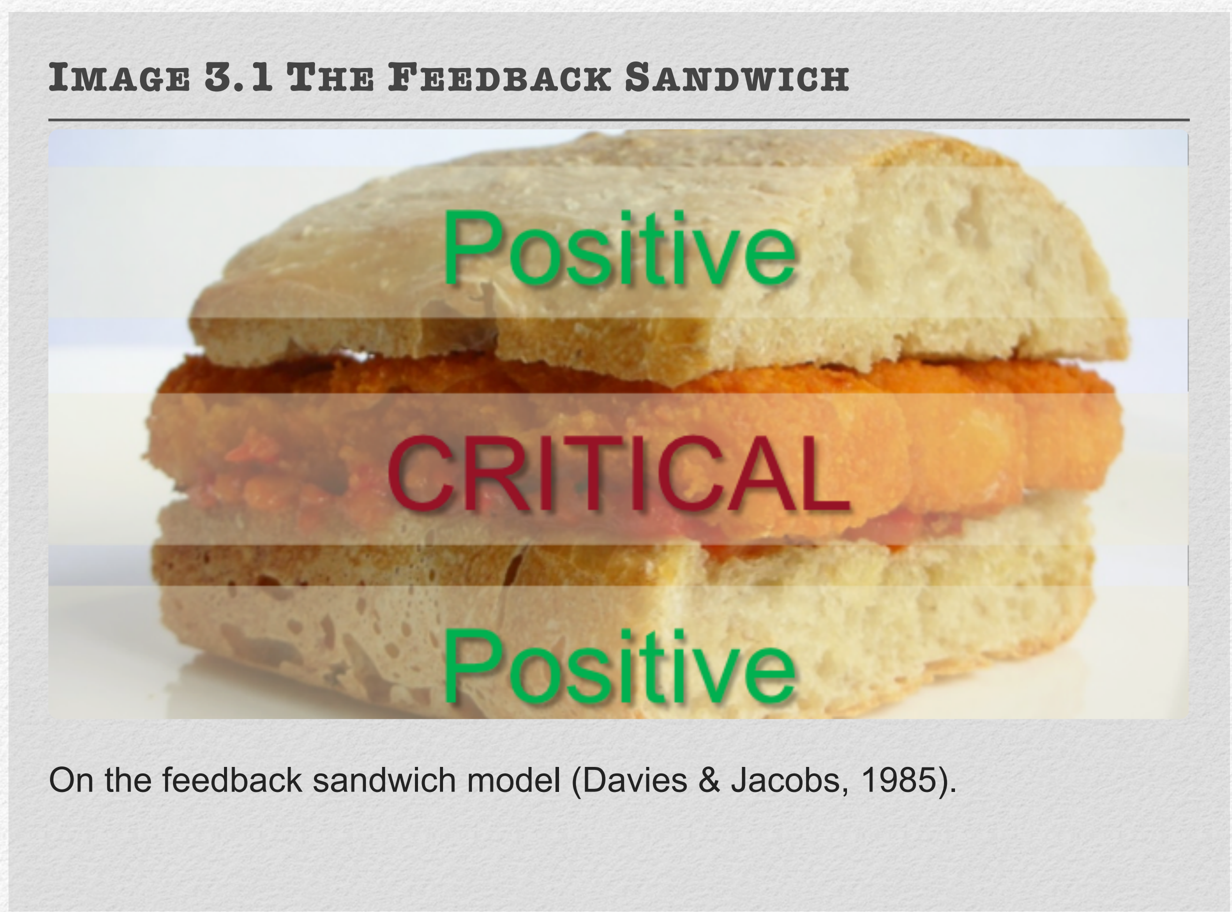
You might have heard of the *feedback sandwich*, another model for giving feedback.

The feedback sandwich model is based on the premise that the feedback recipient will be more receptive to critical feedback if the resident educator reinforces successful performance before and after offering critical comments (Davies & Jacobs, 1985).

The Rationale

Starting and ending with good news helps the learner *save face or avoid embarrassment, and, therefore,* enables them to maintain a receptive attitude when hearing critical feedback. Thus, the intent is to ensure the medical student will be able to operational-

Image 3.1 The Feedback Sandwich



On the feedback sandwich model (Davies & Jacobs, 1985).

ize critical feedback because they will not feel badly about critical feedback, or less confident in themselves.

Limitations

In practice, the feedback sandwich model emphasizes the "personal preservation" of both the resident educator and medical student (Kogan, 2012).

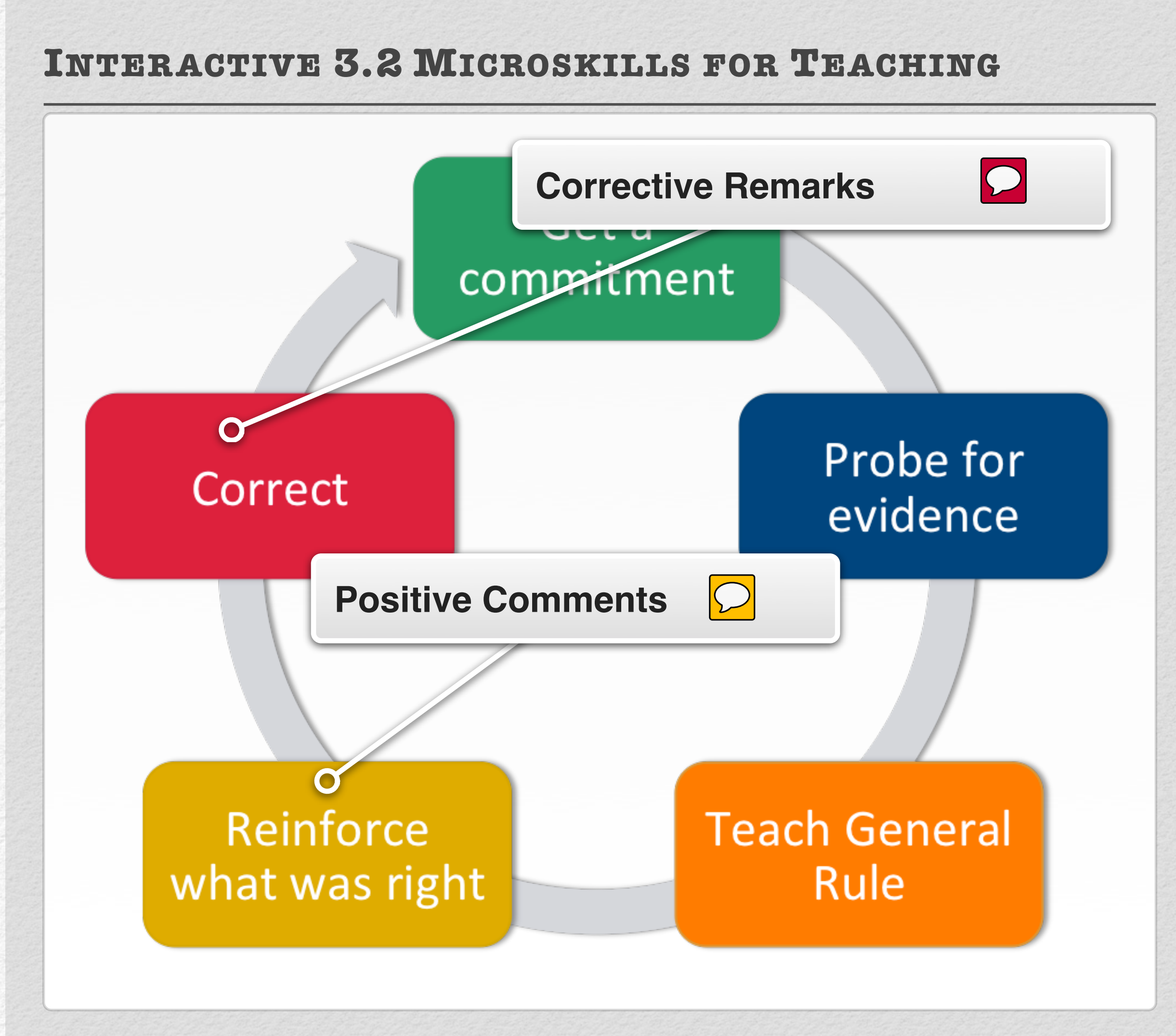
Researchers have explored whether positioning critical feedback between positive reinforcement helps the recipient learn what or how to improve. Some have posited that burying the critique in the middle of something the medical student *wants to hear* might enable the medical student to avoid criticism (Kogan et al. 2012).

Thus, this model draws attention from the primary purpose of giving feedback - to improve knowledge or practices.

> *"Faculty and staff frequently used the feedback sandwich, a technique originally felt to be effective because negative information is sandwiched between positive items.[38] However, some faculty participants in our study recognised the limitations of sandwiched feedback. The feedback sandwich may be a less effective technique because its primary purpose is to shield the medical student and teacher by balancing positive and negative feedback and thereby achieving personal preservation.[9] Feedback has highly variable effects on performance.[11]" (Kogan, et al. 2012, 212).*

A Comment on Microskills for Teaching

The **microskills for teaching** model, also known as the *one-minute preceptor*, reminds clinical educators to offer both positive reinforcement and correction. Its primary purpose is to offer a straightforward approach to bedside teaching. This model does not mandate a particular sequence to these two feedback components.



Interactive 3.2 Microskills for Teaching

Microskills also has been translated as, “See one, do one, teach one.” This reflects a kinesthetic or modeling approach to teaching, but does not offer guidance on how to engage the medical student in feedback.

For this reason, there are many resources online that attempt to define and describe what it means to “reinforce what was right” or to “correct”. Often, such resources promote an approach that encourages specific descriptions of behavior (e.g., see Google Scholar results, Microskills specific feedback). Many publications also recommend that clinical educators adopt a reflective approach to incorporating Microskills in their teaching repertoire (e.g., Google Scholar results, Microskills reflective feedback).

This course, then, suggests using the Reflective Feedback Conversation model, to address these issues.

Summary

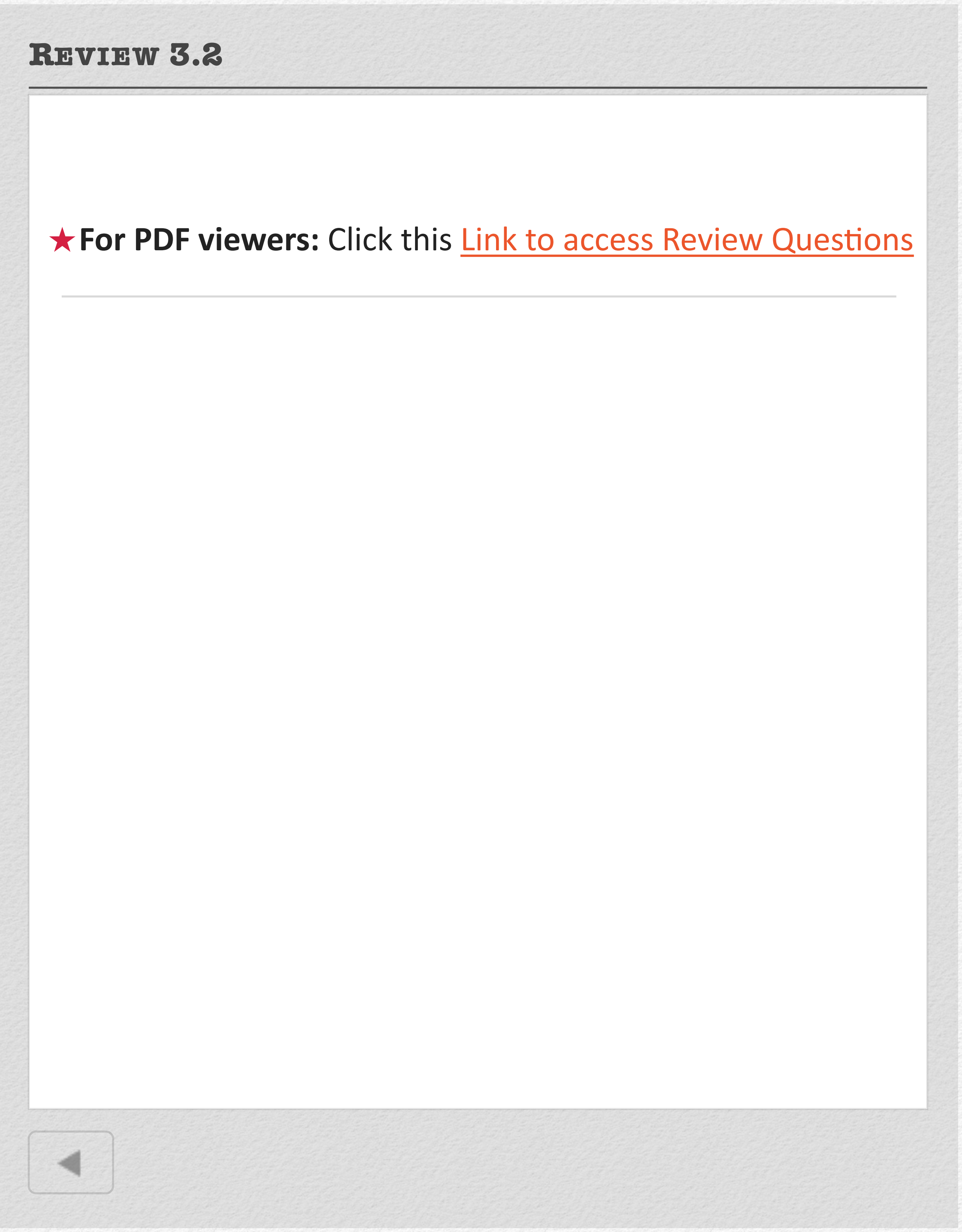
> *Authors agree that in order to improve professional performance, one should first know how he/she is doing and what can be done better through receiving feedback (Davis et al., 2006, Krackov and Pohl, 2011 and Mann et al., 2011). (Boerboom et al. 2015).*

The key to effective feedback is *how* the feedback is delivered, not simply the relative positioning of positive and critical remarks (Kogan, 2013). For example, the *context* or situation as well as the *relationship* between the resident educator and the medical student can affect whether and how receptive the medical student is to corrective remarks. Thus, *communication skills* and *interpersonal dynamics* have demonstrated an impact on the recipient as much as the content of feedback (see Kogan 2013; Kogan et al., 2012).

In addition, encouraging learners to reflect on their own performance, to assess their performance and abilities, and identify their receptiveness to changing practice or improving skills, was recognized as an important aspect of ensuring effectiveness of feedback (Goodyear, 2014).

Review Questions

The review questions address key concepts from this section before moving to the next.



References

Davies D & Jacobs A. Sandwiching complex interpersonal feedback. Small Group Behav 1985;16:387–96.

Neher JO, Stevens NG. (2003). The one-minute preceptor: shaping the teaching conversation. Fam Med 35(6):391-3.

Neher, JO, KC Gordon, B Meyer & N Stevens. A five-step "micro-skills" model of clinical teaching. Journal of American Board of Family Practice 5:419-424; 1992.

Boerboom TBB, Stalmeijer RE, Dolmans DHJM & Jaarsma DADC. How feedback can foster professional growth of teachers in the clinical workplace: A review of the literature. Studies in Educational Evaluation; 2015 (access online at http://www.sciencedirect.com/science/article/pii/S0191491X15000061).

References Cited In The Kogan (2012) Quote:

9 Archer JC. State of the science in health professional education: effective feedback. Med Educ 2010;44 (1):101–8.

11 Kluger AN, DeNisi A. The effects of feedback intervention on performance: a historical review, a metaanalysis, and a preliminary feedback intervention theory. Psychol Bull 1996;119:254–84.

38 Davies & Jacobs (1985).

Concept Review

Key Points

1. **The "feedback sandwich"** is a popular model for giving feedback that, in practice, tends to focus on helping the learner "save face," rather than to learn from critical feedback.

2. **The Reflective Feedback Conversation** is an instructional conversation approach to teaching that requires the instructor to ground both complimentary and corrective feedback in specific descriptions of relevant, observable behaviors.

Section Overview

This final section of the chapter offers a summary of the reflective feedback conversation model and an opportunity to apply it to a simulated feedback experience.

Concept Review

The purpose of the reflective feedback conversation model is to generate an opportunity:

- For a "meeting of the minds" between resident educator and medical student;
- Identify and address gaps in perspective on performance;
- Guide medical students toward becoming more reflective about professional practice in a constructive manner; and
- Build rapport that will provide a strong foundation for future feedback as part of an ongoing conversation.

Practical Application

Please watch the short segment of the video on the next page,

Movie 3.2 An Example of Constructive Feedback

Source; Choo E & Lin M. Giving Effective feedback in the Emergency Department. San Francisco General hospital Department of Emergency Medicine. UCSF and SFGH; 2007 (Used here with permission of the authors, March 4, 2015; copyrighted material available on YouTube, https://www.youtube.com/watch?v=DbfISZjG9mU#t=656

Review 3.3 Chapter Review

For PDF viewers: Click this Link to access Review Questions

Challenges & Strategies

4

This chapter has three sections. Section 1 describes the concept of facework and the factors that may affect the course or outcome of feedback conversations. Section 2 offers strategies to avoid and address challenges. Section 3 describes a framework for teaching that anticipates feedback as part of the routine teaching process.

Strategies for Challenging Dymamics

Key Points

1. **Strategies for addressing challenges** should be cognizant of the factors influencing the communication process.

2. **Re-establishing or clarifying expectations** for performance can avoid misunderstandings in the feedback conversation.

3. **Linguistic strategies** may be used to avoid an accusatory tone, such as replacing the personal pronoun YOU with the pronouns I, we or it.

4. **Reflective Inquiry strategies** aim to promote the medical student's reflective engagement and help identify behaviors, attitudes or skills that the student should learn or improve.

Section Overview

This section describes challenges and three strategies aimed at addressing or avoiding challenges in giving feedback.

Challenges in Feedback Conversations

> *Corrective feedback can be awkward to communicate, and teachers may wish to avoid appear ing critical, particularly in the presence of patients or medical colleagues. But the negative effects of not seeking or giving feedback are considerable (Cantillon & Sargeant 2008, 337).*

You might encounter a medical student who becomes angry about criticism or resists suggestions for improvement. Some might cry or otherwise become embarrassed, anxious or nervous whenever they are about to receive criticism. They are not, necessarily, resistant, but have not prepared themselves or have not been prepared to hear critical feedback.

Such behaviors would cause any instructor some concern not only for the student's development or emotional state, but also because addressing these behaviors is a great challenge even in long-term supervisor/supervisee relationships. In the best of circumstances, residents might have a few shifts with students - not a great deal of time to cultivate a sense of mutual trust and confidence.

The impact, then, of these types of challenges is especially difficult for residents teaching medical students. Some residents might avoid giving feedback altogether, or decide enlist the feedback sandwich to cushion critical feedback with compliments. But, as discussed in the previous chapter, this approach can draw the learner's attention from the critiqued behavior toward what they would prefer to hear.

Below are three strategies to guide you in providing the much needed constructive feedback to medical students who present (or where you anticipate) these sorts of challenges.

Strategies to Address/Avoid Challenges

Strategies for addressing challenges should be cognizant of the factors influencing the communication process described in Chapter 2, including the nature and length of your relationship with the student, the type or or outcome of the specific patient encounter, and the student's receptivity to feedback.

Below are described three strategies with examples, designed to help you avoid or address such challenges when giving feedback to medical students.

1. Re-establish or clarify expectations.
2. Translate the accusatory you to I/we/it statements.
3. Promote reflective engagement through inquiry.

Gallery 4.1 Meet The Challenges

Everyone is different and not all medical students are confident in who they are or who they want to become.

Click the paper clip to view the Gallery

Strategy No. 1 - Re-establish Or Clarify Expectations

Expectations anticipate performance. Whenever you are responsible for teaching a medical student, it is important to establish expectations for the student's engagement in patient care and other performance in the clinical setting BEFORE the student begins the shift. This does not have to take much time. In fact, it can be done on a case by case basis.

The BDA framework can be used to teach in clinical settings. BDA stands for Before, During and After.

BDA refers to your interaction with the medical student Before, During & After the clinical encounter. BEFORE the encounter you can establish or clarify expectations for performance. AFTER the encounter, you can debrief with the student, anchoring your feedback in the expectation you established beforehand (Interactive 4.1).

We should always ask ourselves: What is the learning objective of the student (apart from the patient care objective)?

BEFORE

Thus, **BEFORE** we send a student to interview a patient, we should find out what they know and can do without assistance and what they COULD do with assistance and supervision. This assists us in establishing reasonable expectations for performance and learning objectives in the clinical setting.

For example, if the patient needs a knee exam, find out if the student has ever done a knee exam. Do they feel comfortable doing one alone? Do they know the difference between and the respective reasons for doing passive and active knee exams? Given what you know about a particular patient, what kind of exam do they think is necessary?

Once you know what the student knows and can do without your assistance, you can establish reasonable expectations for the student's engagement in that patient's examination. At least part of what the student will do should be new to them, something they could do with assistance or guidance.

DURING

The task the medical student can do WITHOUT assistance offer practice at known skills. The task the medical student can do WITH assistance or supervision offers a chance to learn something new - the learning objective.

You will not have the time to observe every clinical encounter in which the student engages, and likely will choose not to super-

vise directly the things the student has established they can do well without direct assistance.

You should observe the tasks that are new to the student, and which require your guidance or assistance to perform effectively.

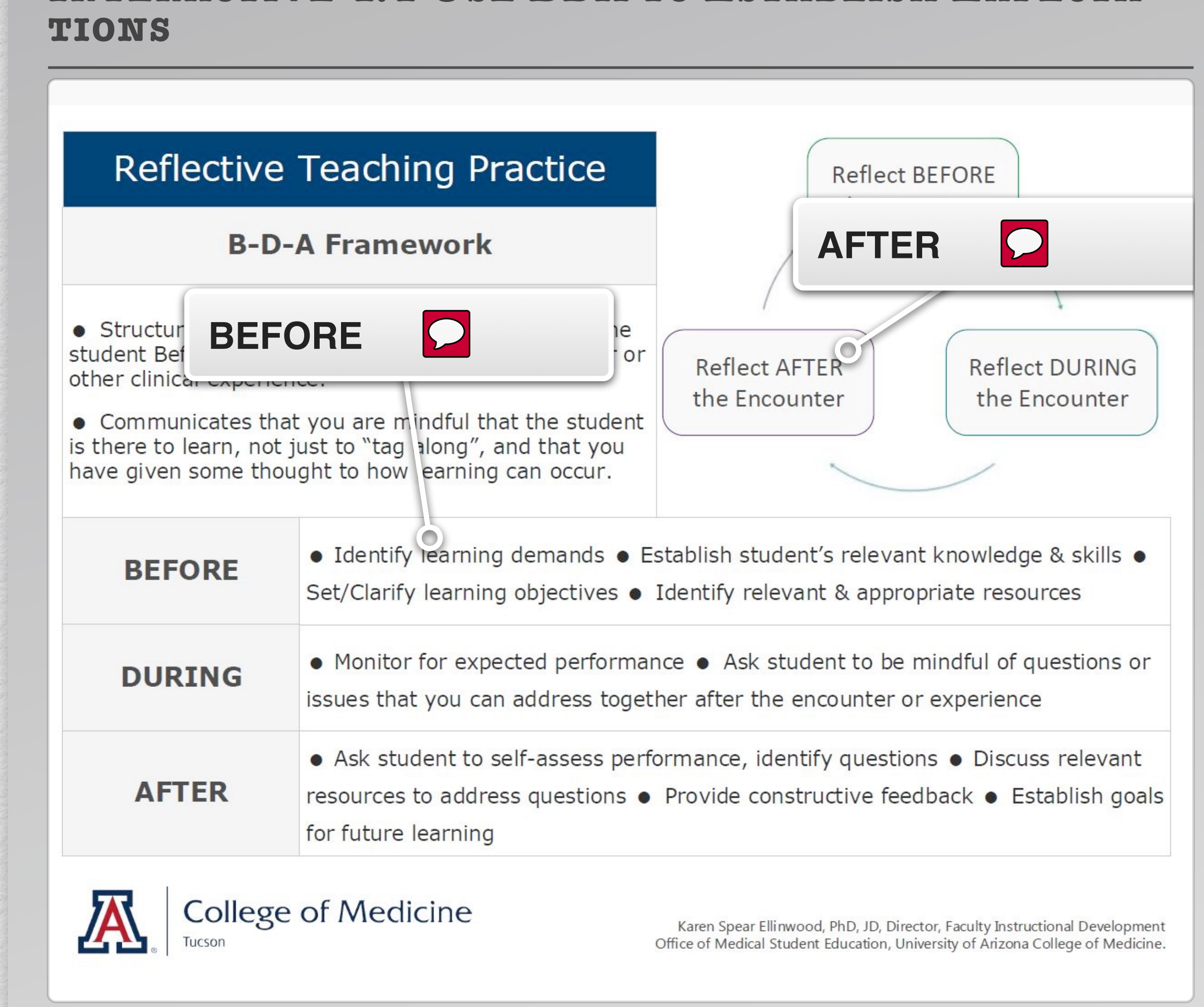
DURING the encounter, then, you should plan to be in the room to observe and to offer feedback after the patient encounter on this specific learning objective.

AFTER

AFTER the encounter, you should offer feedback anchored to these expectations. This can help to avoid challenges in giving feedback because the expectations were establish BEFORE the encounter, and the student has been able to anticipate the sort of feedback they might receive.

Sometimes it becomes apparent AFTER an encounter, that the student misunderstood the expectation or did not know how to operationalize it. This might cause the student some apprehension about receiving feedback. In this situation, it would help to **clarify** the **expectations before offering critical feedback,** and help the student identify the origin of the misunderstanding or articulate the difficulties in implementing them.

Interactive 4.1 Use BDA to Establish Expectations



Bottomline

The BDA framework for clinical teaching, then, can be used to identify a gap between the student's perception and yours BEFORE an encounter. The reflective feedback conversation as an opportunity to re-establish or clarify those expectations AFTER the encounter.

Where do you find the learning objectives to establish or clarify expectations?

If you are unclear about what the learning objectives are for medical students in the clerkship or other rotation in which you teach, there are several resources at the UA College of Medicine.

Expectations for what medical students should be able to know or do by the time they graduate are established by the UA CoM's Educational Program Objectives.

Learning objectives for clerkships in third year are established by the General Clerkship Manual. This manual is available online.

Learning objectives for medical student performance in particular clerkships are set forth in the manual for the specific clerkship in which the student is participating, e.g., Family & Community Medicine, Pediatrics, and so on. These objectives identify specific procedural skills students are expected to perform or observe, medical knowledge they need to learn, and attitudes or behaviors in terms of communication and professionalism expected to demonstrate by the time they complete the clerkship.

The Clerkship Directors and Coordinators can provide you with an electronic copy (usually PDF) of the specific clerkship manual, assessment instrument and related resources. If you do not have one for the clerkship in which you teach, please ask the Director or Coordinator.

Offering Feedback as Part of Assessing Medical Students

You might be asked to participate in assessing the medical student, either at the mid-point (formative assessment) or at the end of the clerkship (summative assessment, grading). The assessment instrument is an online survey.

The assessment requires you to comment on the student's performance, in addition to a scaled score. Your comments should follow the same guidelines as are in this feedback model. In other words, please include a description of specific, relevant observable behaviors for both complimentary and critical feedback.

Assessment Training

The Clerkship Director usually provides for training on how to assess students in the orientation of residents to teaching in the clerkship. You also may consult the Manager for Curriculum and Assessment, Susan Ellis, MA, EdS, in the Office of Medical Student Education (OMSE) if you have any questions on how to assess student performance in clerkship.

What about Expectations of 4th Year Medical Students?

Each internship or sub-internship in which fourth year medical students participate has learning objectives that outline expectations for student behaviors, skills and attitudes.

The Attending assigned to supervise the internship can provide you with a copy of those expectations if you are asked to supervise or teach the medical student during that clinical rotation. The Manager for Curriculum & Assessment (Susan Ellis, MA, EdS) may also help you locate the learning objectives for any rotation in which you are responsible to teach or assess medical students.

In addition, there are *profession-wide guidelines* establishing what medical students ought to know and be able to do by the time they graduate from medical school. Therefore, a medical student in their final term could benefit from a discussion of the ACGME Core EPAs (Entrustable Professional Activities). These represent **long-term goals** for medical students to strive to achieve.

The Core EPAs include how to:

- Conduct a history and physical examination;
- Develop a problem list as well as differential diagnosis;
- Present cases;
- Conduct bedside teaching with medical students; and
- Interact with colleagues and other health care professionals.

Strategy No. 2 - Translate The Accusatory YOU To I/We/It Statements

The tone we use and the way we set up the feedback conversation will set the mood for the learner and may affect their receptivity to future feedback.

Personal pronouns can also make a difference in the mood we set. If you anticipate that the learner may become defensive or has demonstrated a tendency to be resistant to critical feedback, consider translating the personal pronoun YOU to WE, I or IT.

The Accusatory YOU

YOU statements intended to convey criticism - even if accurate, might cause some learners to react defensively or feel embarrassed. Since the aim is to avoid triggering feedback resistance, we can translate critical YOU statements to I/WE/It statements. One way of doing this is to use WE statements to re-establish or clarify expectations.

Consider the following Safe Discharge Plan Scenario

Patient is an 89 year old female married patient who had been admitted for injuries due to a fall at home. The fourth year medical student is asked to interview patient's husband to gather ideas for a safe discharge plan. Patient has dementia and is a fall risk. Patient's husband uses a walker and has low blood pressure. He tells the student that their great-granddaughter lives with them. He proud that

she is a graduate student at the University of Arizona in Medical Humanities.

The medical student feels assured by this fact and suggests a plan allowing the patient to return home. Had the medical student spoken with the great-granddaughter, she would have learned that she spends little time at home, works 30 hours a week plus attends school full-time. She has no car to assist with transportation to doctor visits and is the only family who lives in town.

You need to offer constructive feedback on the student's suggested discharge plan. Review the two versions, below, of feedback that could be offered. The analysis that follows illustrates this strategy by highlighting the differences between the YOU statement and the translation. The same format is used in other examples of this strategy.

Example 4.1 YOU Statement

Based on the above scenario.

Example 4.2 Translation

Based on the above scenario.

Gallery 4.2 The Accusatory & Complimentary YOU!

Some feedback recipients might feel defensive or display a negative emotional reaction, and perceive the pronoun YOU as an accusation when it accompanies critical feedback.

Click the paper clip to view the Gallery

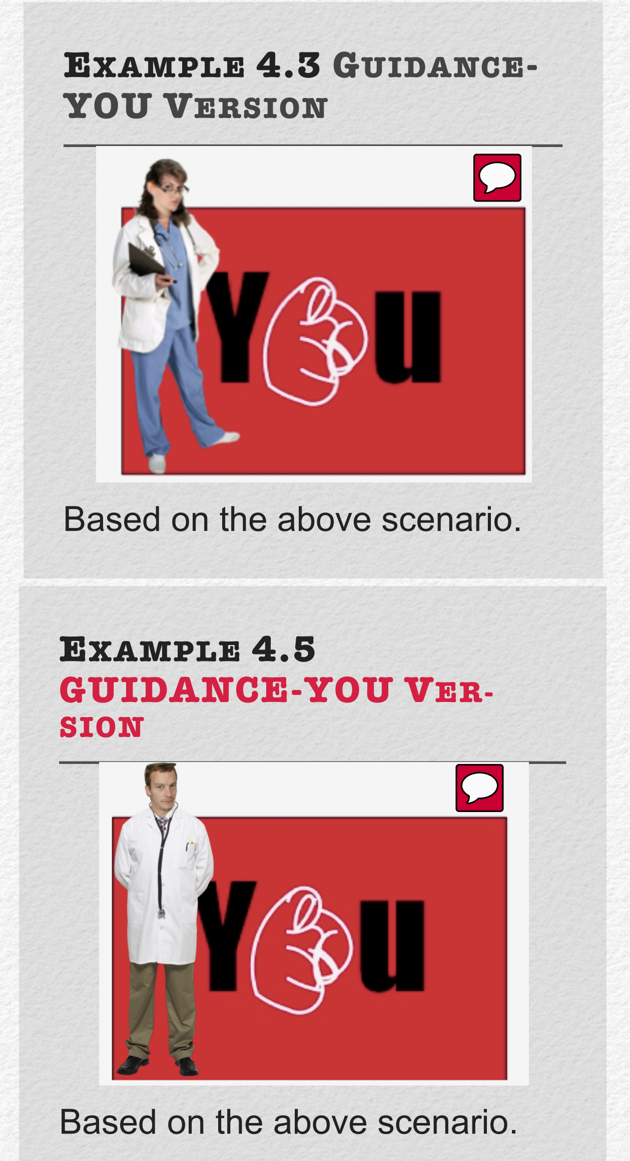
Critical Feedback: Translation Analysis

The YOU statement in Example 4.1 tells the student what they need to work on - breaking down compound questions into straightforward ones. But, the use of the personal pronoun YOU conveys an accusatory tone, which might cause some students to feel resistant to receiving and acting on the feedback.

WE statement in Example 4.1, reminds the learner what they should consider when gathering information to develop a safe discharge plan. It seizes feedback as an opportunity to clarify expectations for the task assigned.The WE pronoun enables the resident to establish the **professional norm for competent behavior** without sounding accusatory.

Actionable Guidance Examples

Examples 4.3/4.4 and 4.5/4.6 illustrate guidance the resident could offer to the medical student in the same scenario. Each of these has a YOU version and an I/We/It Translation.



Actionable Guidance: Translation Analysis

Notice that **the YOU statements feel more like “gotcha” moments.** Whereas the WE Translations illustrate that feedback is an opportunity for teaching or mentoring, a chance to help the

medical student develop the skills, behaviors and attitudes necessary for effective and reflective practice.

The I/We versions contain a concrete description of the relevant, observable behavior that triggered the feedback. This description puts the medical student on notice as to WHAT they need to improve and HOW to approach the discharge planning process.

WE translations are more wordy because they tend to use an indirect communication style. However, they also avoid an accusatory tone, making it more likely the learner will feel receptive to critical feedback.

Each WE statement includes an explanation for why the medical student's behavior could present problems in creating a safe discharge plan. These explanations qualify as descriptions of relevant observable facts.

Each WE translation also serves as providing actionable guidance, advice contextualized by what has proven helpful to the resident educator, an experienced practitioner. This is a key component of constructive feedback and reflective feedback conversations.

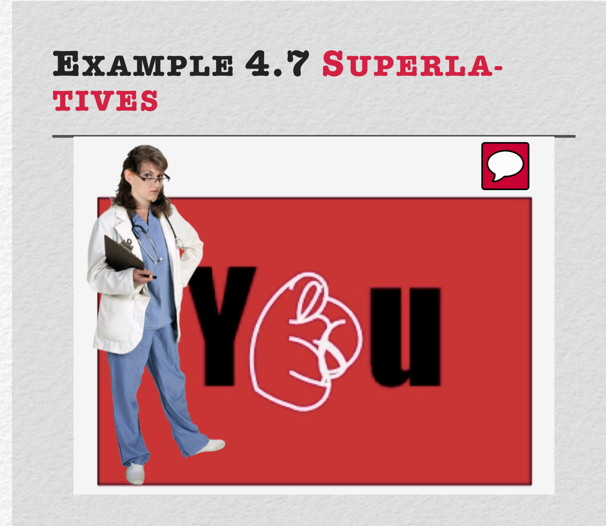
Example 4.7/4.8 - Superlatives

The Translation strategy for the "accusatory YOU" targets personal pronoun usage in giving feedback. We should also consider how we use adverbs and superlatives when offering feedback in person or in writing. But, in general, linguistic strategies ask us to be mindful of HOW we phrase feedback.

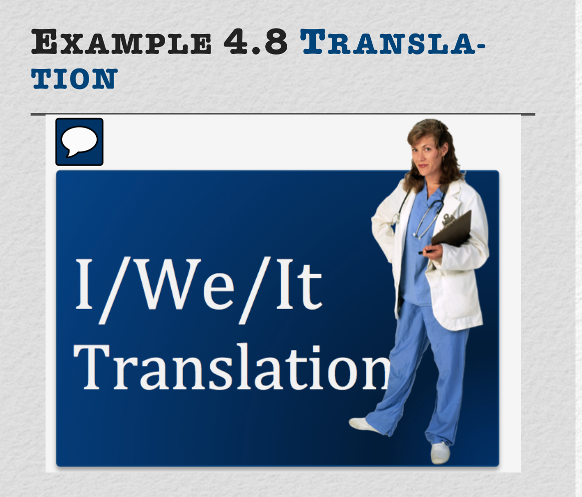
As a general rule, then, we should be cautious about our use of any language that might incite resistance to feedback. Superlatives or adverbs (especially when used in critical feedback) can sound derogatory. We want to avoid **hyperbole**.

Therefore, we should consider whether the particular descriptives we plan to use sound like "overkill" (whether intended as positive or critical remarks).

Compare the YOU and I/We/It Translation of superlatives below.



Example 4.7 Superlatives

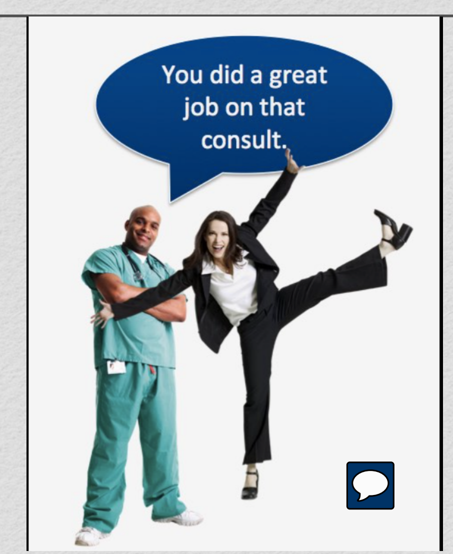


Example 4.8 Translation

Superlatives: Translation Analysis

In the YOU Statement in Example 4.7, the resident educator uses superlatives to emphasize certain behaviors: "your voice is **so** low...it's **almost impossible** to hear you...you **really** need to speak up...If you had **actually** done that". These terms in bold do not convey helpful information, but they might **convey a complaining** or **derogatory tone.**

Example 4.9 Complimentary YOU! :)



The Translation in Example 4.8 removes the superlatives and translates the YOU to IT and WE where appropriate. In short, it conveys the important part of the message, that the student should be mindful of and accommodate a patient abilities rather than address every patient in the same manner.

This translation accomplishes the intended message - speak louder with elderly patients, without ringing an *ad hominem* tone about the medical student's soft voice.

Don't Translate the Complimentary YOU

We cannot avoid saying the pronoun YOU in every instance. So when is it best to say YOU?

When YOU statements affirm **good** performance, the recipient is happy to hear the personal pronoun YOU. It *allows them to take credit* when they should.

In Example 4.9, the resident uses the personal pronoun YOU to deliver the compliment ("excellent job") and follows it with a description of relevant, observable behaviors to support it.

Bottomline

To promote improvement in performance, we should consider not only **WHAT** to say but **HOW** to say it to facilitate the learner's improvement. The WE pronoun can help the medical student escape embarrassment, without enabling the learner to avoid feedback intended to help them improve their skills and knowledge.

Strategy No. 3 - Use Reflective Inquiry To Promote Self-assessment And Reflective Practice

Reflective Inquiry strategies aim to promote the medical student's reflective engagement and help identify behaviors, attitudes or skills that the student should learn or improve.

In other words, encourage the medical student to think out loud about what they did, how and why they did it, and how they might do it better next time.

Some students are receptive to this type of inquiry, especially when it is done collaboratively with you guiding the discussion.

However, sometimes, a student might present a different recall of events or a divergent perspective. The student might say, “Oh, yea, I did that”, or “I covered that already”, or try to diffuse attention by saying they already know what they need to do next time.

A student might give other clues that they are not willing to admit error. Or, you might conclude they truly do not understand that what they did failed to meet expectations. This reaction could be a one-time, reflexive defense mechanism because the student feels embarrassed. Sometimes, we encounter a student who does this consistently, demonstrating a pattern of resistance to feedback.

Regardless of the reason, if a medical student does not seem to understand your concerns for their behavior or performance, *you could invite them to think about the situation from another perspective*. This type of reflective inquiry strategy engages the student metacognitively in reflecting on performance without making it feel personal.

Gallery 4.3 Socratic Questions as Reflective Inquiry

Question the Case	Question Perspectives

estions to separate fact from opinion
What evidence do we have?
do we know what is true/accurate?
else do we need to know to address this patient’s
erns?

estions to investigate reasons/rationales
How can we narrow POSSIBLE causes to highly
SIBLE ones?
should we rule out urgent causes?
did you decide to favor one theory of this case over
her?
in how you arrived at your conclusions.

estions to clarify meaning
Which facts make you think we are taking the right
oach or have reached the right conclusion?
would you explain ____?
does [____] mean?

Questions about perspectives & biases
- How could we (re)frame our questions?
- Have we framed our inquiry in a way that helps or hin
from reaching a conclusion supported by evidence?
- How can we reframe the question to identify essentia
and questions?
- What have you learned from assessing past cases?
- How can prior cases inform your thinking in this case?

Questions about the question
- What kind of questions should we be asking?
- Why do you think we should be asking this question?
- How are you applying knowledge or reasoning in this
tion?

Socratic questions can promote discussion and encourage the student’s reflection to guide future performance, not simply to identify errors in past performance. Socratic questions, for example, investigate the case, perspectives, the process, and future learning or approaches to patient care.

For example, we could ask a medical student to imagine how:

- The patient might have interpreted the behavior;

- A nurse or other health care professional or attending who observed the interaction might have reacted; or
- How they would feel if they stood in the patient's shoes.

This reflective inquiry strategy asks the medical student to place themselves outside of the personal space and into a broader, professional or inter-professional perspective and context. The medical student should be encouraged to articulate why they think the interaction or conduct could be interpreted in that way to help them identify specific behaviors in need of correction. If the student is able to identify the concerning behaviors, they have met you halfway to giving the critical feedback they need.

Socratic questions, which can be used throughout an interaction with a student, involve reflective inquiry, Gallery 4.3 displays four categories of reflective questions with examples.

Socratic inquiry can be used to encourage medical students to:

- **Articulate** reasoning for inclusion or exclusion of possible diagnoses; patient expectations for the visit;
- **Examine** whether the evidence warranted inclusion or exclusion, or if the visit met patient expectations; and
- **Describe** how we determine whether the evidence warrants ruling in or ruling out certain conditions; or how we should perform a particular procedure, exam, interview, or other aspect of the patient encounter to meet the patient's expectations.

Bottomline

Reflective Inquiry strategies are designed to help learners think out loud about other possibilities as well as examine what they did or did not do.

More Feedback Pearls

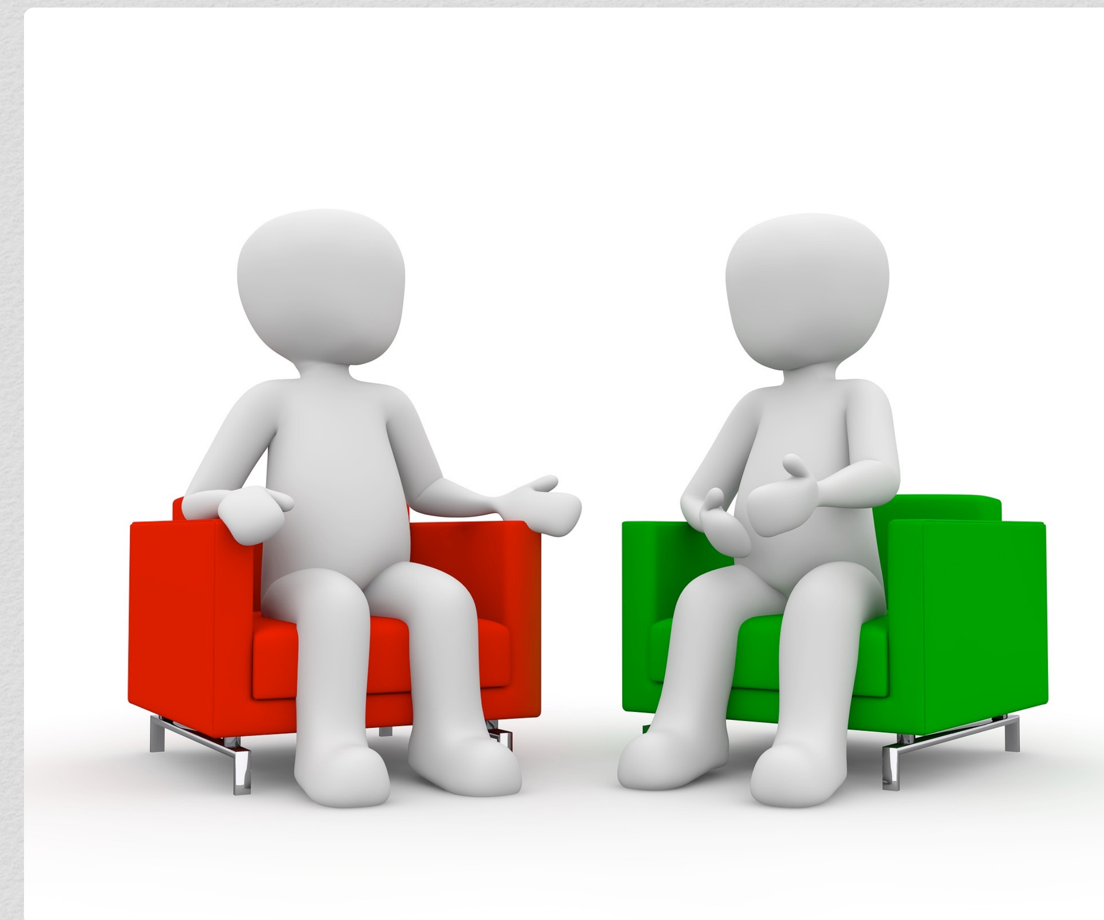
Generate A Plan For Improvement & Follow-up!

When a medical student fails to follow through on suggestions for improvement, applying the reflective feedback conversation model may help establish a shared understanding of the BEHAVIORS that caused the failure to follow through.

This should include asking the medical student to articulate their REASONING. The process of articulating one's reasoning can assist the learner in recognizing the problem, identifying gaps in understanding, and reaching common ground with the educator.

Therefore, a reflective feedback conversation should:

Gallery 4.4 Summary & Review



REMINDER: Prepare the learner for feedback. Frame it as a conversation.

Click the paper clip to view the Gallery

- **Generate a PLAN** for improvement, that is, an agreement as to what needs to be improved and *how* the student will follow through (specific steps, behaviors the medical student will take); and
- **Schedule a FOLLOW-UP meeting** to discuss their progress on the plan.

You might not be the person to follow-up, but you can help the student generate the plan and alert the attending or clerkship director so they can follow up to assist the student in achieving their learning goals for the clerkship and beyond.

The plan can be aimed at short-term goals, such as engaging effectively in a particular encounter, or succeeding in the clerkship. The plan could also target long-term goals, such as developing knowledge and skills necessary to graduate or enter residency.

Location, Location, Location!

Location is an important aspect of avoiding challenges or repairing threats in the feedback process. When a resident educator anticipates offering constructive correction (suggestions for how to deliver bad news in future situations), especially on a sensitive topic or in an emotional situation, the medical student reasonably expects the feedback conversation to be conducted in a pri-

vate space. Taking the time to find a private space could avoid medical student's defensiveness or feeling embarrassed - both of which could affect the success of the feedback conversation.

Corrective or critical remarks on how to conduct a patient interview or present a case could be offered in the "doc box" or similar settings where others might be present but not attending to your conversation. However, corrective remarks about personal matters, such as professional attire or personality conflicts should be offered in private. Discussing these matters with a student, for example, in the hallway, the doc box, a room without a door, or in a patient care area would invite the challenges we all seek to avoid - defensiveness, emotional upset, and resistance to feedback.

Securing a private space tells the medical student that you respect their privacy. The conversational and supportive approach suggested here should encourage the learner's receptivity to feedback in the specific instance and in the future.

Bottomline

Feedback is a teachable moment. Giving or receiving critical feedback poses challenges. Critical feedback should respect the privacy of the learner. A plan for improvement should identify the student's learning goals, describe the specific behaviors to be improved, and strategies for and a timeline for progress toward improvement.

Summary

Feedback Is A Teachable Moment

Giving helpful, formative feedback presents you with a teaching opportunity. How you give feedback models for the learner a method for them to emulate when they need to provide feedback to peers or medical students when they become residents.

Giving/Receiving Critical Feedback May Pose Challenges

Corrective feedback may cause some medical students to feel embarrassed, anxious or emotional. While it is not possible to avoid such reactions in every feedback conversation, it is important to be mindful of the possibility of their occurrence and to do y our best to avoid negative impact or generate in the recipient- a lack of receptivity to critical feedback.

There Are Strategies To Address/Avoid Challenges

A resident educator may use several strategies to ensure the medical student understands and is receptive to critical feedback, including:

- Re-establish or clarify expectations.
- Translate the accusatory you to I/we/it statements.
- Promote reflective engagement through reflective inquiry.

Gallery 4.4 summarizes the reflective feedback conversational model and the feedback strategies described in this chapter.

Additional Resources

Schute (2008) offers practical tips for giving formative feedback and citations to additional literature on formative feedback.

Media Credits

Gallery 4.1

Image No. 1, Source: Spear Ellinwood, KC. Accusatory YOU (with hand and red background).

Image Nos. 2, 4, & 5, Source: Microsoft Office for Mac Clip Art.

Image No. 3, Source: Lovati S. Several people pointing at man https://www.flickr.com/photos/lovati/5007008029; 2008.

Gallery 4.2

Reflective Feedback Conversation model: Conceptual graphics by the author.

All images are downloaded from Pixabay.com and do not require attribution.

Feedback Practice & Review

Key Points

1. **This final section** offers an opportunity to apply the reflective feedback conversation model to a patient encounter scenario involving a medical student, and to identify strategies to avoid or address challenges presented.
2. **The Scenario Feedback** provides examples of the feedback we could offer the medical student in the scenario applying the model and strategies discussed in this course.
3. **This section closes with several review questions** to help you prepare for the final assessment.

Section Overview

This final section of Chapter 3 includes:

★Section Review Questions

★Activity - Feedback Practice: Apply Strategies to Cases Involving Feedback Challenges

Practical Application & Instructions

For the scenario below, apply the reflective feedback conversation model and strategies for avoiding or addressing feedback challenges to the case scenario, and answer the review questions.

Following each section of the scenario (Background, Patient Encounter, Case Presentation), click on the pop-up image to review the analysis of the scenario and the feedback we could offer the student. Each feedback example applies the reflective feedback conversation model and strategies discussed in this course. Before reading the scenario, please consider the Questions below.

Questions for Consideration

Before reviewing the Feedback Scenario, consider the following questions. These should guide you in deciding not only what behaviors you want to address, but how you might want to phrase

your feedback, as well as how you would want to engage the student in the feedback process.

Describe Relevant, Observable Behaviors

1. What *behaviors*, attitudes or knowledge demonstrate this student meets or does not meet reasonable expectations for

    1.1. Patient care in general,

    1.2. Conducting a patient interview, and

    1.3. Making a case presentation.

Complimentary & Corrective Feedback

2. What complimentary and corrective feedback would you offer?

Actionable Guidance

3. What *actionable guidance* would you offer?

Inviting Self-assessment (Involving The Student)

4. How would you involve the student in the feedback process?

Applying Strategies To Avoid/Address Challenges

5. If you anticipate this student might be defensive, how could you:

    5.1. Re-establish or clarify expectations?

    5.2. Translate the accusatory YOU to I/We/It statements?

    5.3. Use inquiry to promote the student's reflection on practice?

Feedback Scenario

Background

You are Dr. Beneficent, a resident in Family & Community Medicine working at a local community-based clinic. You have been assigned to supervise a third year medical student who is halfway through the clerkship. The student has completed four other clerkships.

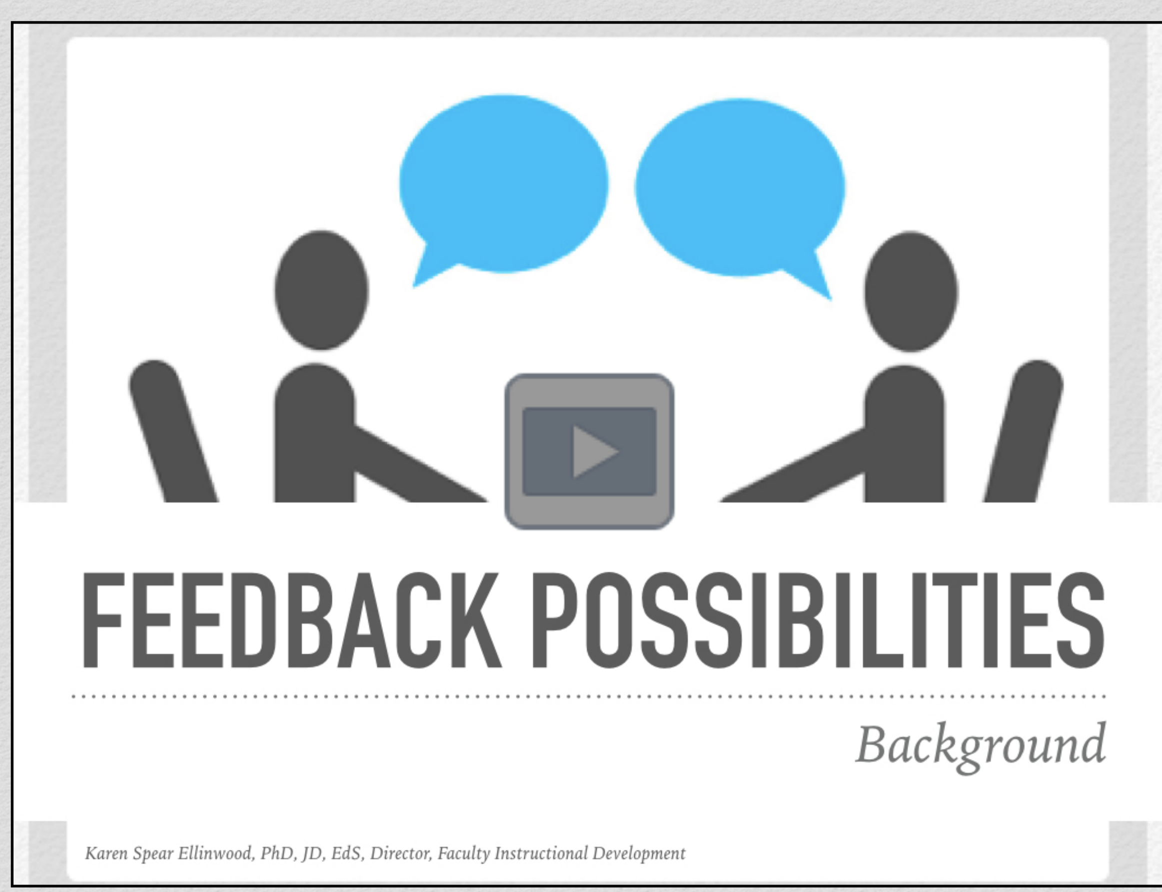
Two of your peers have said that this student has been defensive when they had supervised and offered critical feedback, but did not provide any details.

A return patient is waiting to see you. She is a 48 year old, homeless woman with a previously diagnosed deep vein thrombosis. Her EPIC chart indicates she is not a candidate for Coumadin/Warfarin treatment.

The EPIC patient chart is open on the screen and you suggest the student review it for background information. The medical stu-

dent glances at it for a minute, and then goes to the patient's room to conduct the interview and physical. There is a computer in every patient room.

Interactive 4.2 Possible Feedback RE: Background



Click the paperclip above to view the presentation addressing the Questions for Consideration concerning the **Background**.

Patient Encounter

Medical Student: Hi Ms. Smith. I see you've got a DVT and you came in to get some treatment.

Patient: Are you my doctor? [Patient seems nervous]

Medical Student: Yes; Dr. Beneficent asked me to see you.

[Patient nods]

Medical Student: We can do an ultrasound to check your DVT. But you've been diagnosed already. I understand you didn't complete the treatment.

Patient: I couldn't. I couldn't take the medication they gave me. I'm at the shelter.

Medical Student: Well, DVTs can be serious. So we should get you started on a treatment regimen. We can start you on Coumadin get you back home as soon as possible.

Patient: I don't have a home. I'm staying at a shelter. Sometimes with people.

Medical Student: Oh, I do remember seeing that. But, you should be able to take Coumadin as an outpatient.

Patient: I don’t think I can take that drug. It sounds familiar. But, I think it’s a drug I’m not supposed to take. I don't know why. I'm not sure.

Medical Student: Okay, well, we can check your records on that. But regardless we should be able to get you started on something today and get you out of here shortly.

[Patient is silent as the medical student examines her.]

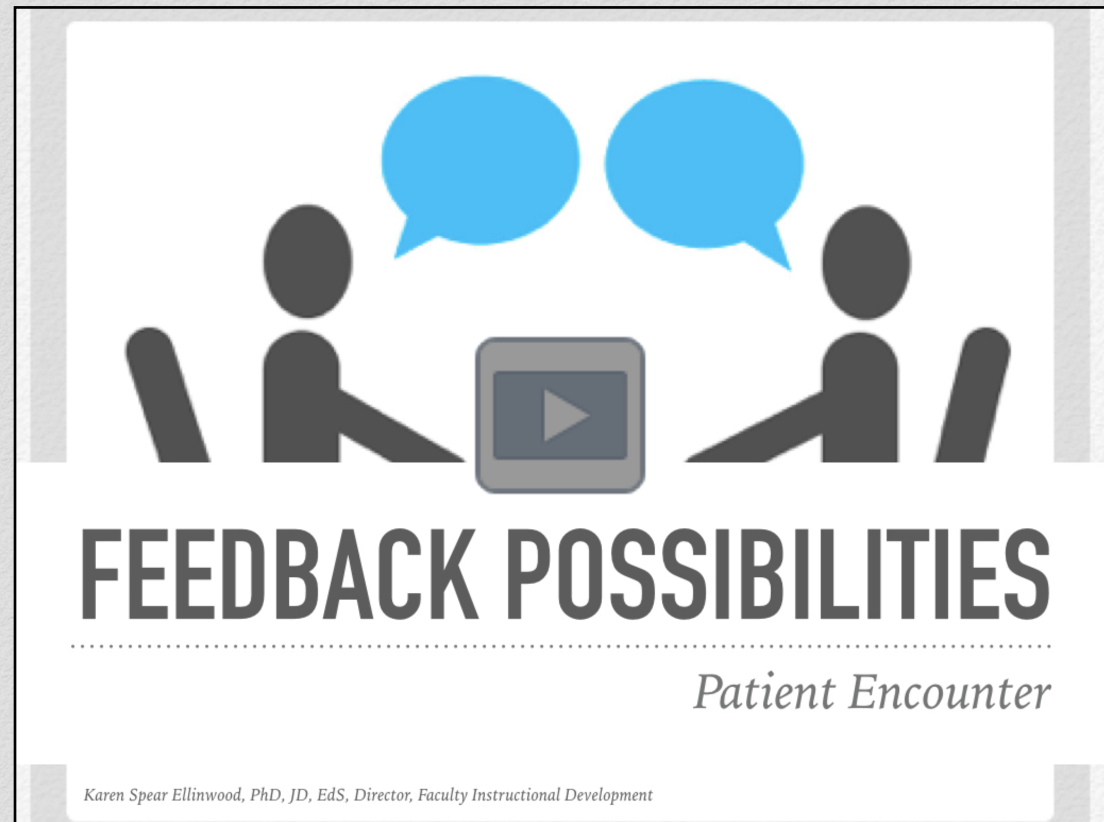
Medical Student: Where are you staying?

Patient: I don’t have a place, but at night I stay in a shelter.

Medical Student: Okay, well, that’s fine. We can send you home with medication to take while you’re there.

Patient: Okay.

Interactive 4.3 Possible Feedback RE: Patient Encounter



Click the paperclip above to view the presentation addressing the Ques-tions for Consideration concerning the **Patient Encounter**.

Case Presentation

The medical student presents the case to you as follows:

MS: This is a 48 year old female with a known DVT, upper right arm. She was previously diagnosed at this clinic but did not complete treatment. She can be started on Coumadin today. She has a place to stay at a local homeless shelter.

Interactive 4.4 Possible Feedback RE: Case Presentation

Click the paperclip above to view the presentation addressing the Ques-tions for Consideration concerning the **Case Presentation**.

Assessment & Course Evaluation

This chapter contains links to the post-course assessment. Completion will certify your participation in the course and count as credit toward compliance with the UA CoM policy requiring 2 hours of annual residents as educators training.

Course Examination & Evaluation

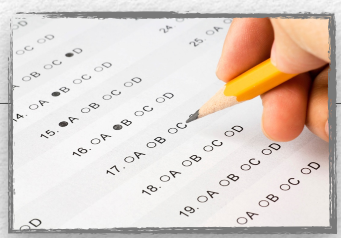
Key Points

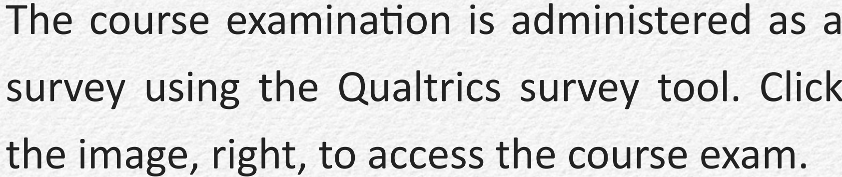
1. **Passing the final examination** fulfills the UA CoM policy requiring residents to complete two hours of residents as educators training each year.
2. **The Course Evaluation** will be used to help improve the content and format of this RAE course.
3. **LINK to Course Exam.**
4. **LINK to Course Evaluation**

Final Course Examination

The final exam addresses all course concepts and strategies.

Take The Course Exam Online





The course examination is administered as a survey using the Qualtrics survey tool. Click the image, right, to access the course exam.

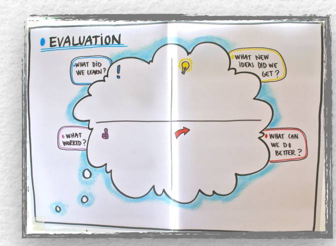
Exam Score Is Instantaneous

Each participant receives an instantaneous score for the final examination.

Course Completion Verification

To verify course completion, the first item asks for your name, department and residency program affiliation.

Course Evaluation



Your feedback is important to help improve this course. Please click the image to submit a course evaluation.

Note: iBook version has an additional page # 72 in this section that is blank.

Resources & References

This chapter contains two sections. Section 1 contains references to scholarly resources cited in this book as well as additional references on the topic. Section 2 contains additional resources to expand your learning on the topic.

References

Key Points

1. **There are many scholarly articles** published on the topic of feedback in the field of education in general, higher education and medical education, in particular.
2. **The references** included in this section informed the content of this course.
3. **References are listed by four categories**: (1) Feedback and Formative Assessment; (2) Communication, Discourse and Facework; (3) Educational Frameworks; and (4) Metacognition and Self-regulation.
4. **References in bold font** are cited in the course.

Section Overview

This section contains references to scholarly, peer reviewed articles and other reputable references on the topic of feedback and evaluation in medical education.

List of References

The referenced articles are listed in alphabetical order. References in bold font are required readings.

Feedback & Formative Assessment

Cantillon P & Sargeant J. Giving Feedback in clinical settings. British Medical Journal 337:1292-94; Nov 2008. [Reflective Feedback Conversations]

Chan PE, Konrad M, Gonzalez V, Peters MT & Ressa VA. The Critical Role of Feedback in Formative Instructional Practice. Intervention in School and Clinic. published online 29 May 2014 accessed at http://isc.sagepub.com/content/early/2014/05/23/1053451214536044.

Choo E & Lin M. Giving Effective feedback in the Emergency Department. San Francisco General hospital Department of Emer-

gency Medicine. UCSF and SFGH; 2007 (copyrighted material available on YouTube at http://youtu.be/DbfISZjG9mU).

DeWitt D, Carline J, Paauw D & Pangaro L. Pilot study of a RIME-based tool for giving feedback in a multi-specialty longitudinal clerkship. *Medical Education 42*: 1205–1209; 2008.

Elnicki D & Cooper A. Medical Students' Perceptions of the Elements of Effective Inpatient Teaching by Attending Physicians and Housestaff. J Gen Intern Med 20(7): 635–639; Jul 2005.

Ende J. Feedback in clinical medical education. JAMA 250(8):777-81; 1983.

Gigante J et al. Getting Beyond "Good Job": How to Give Effective Feedback. Pediatrics Vol. 127, No.2; Feb, 2011.

Hatem C. Teaching to Promote Professionalism. Acad Med 2003; (7):709.

Hewson MG & Little ML. Giving Feedback in Medical Education. *Journal of General Internal Medicine,* 13: 111–116; 1998. doi: 10.1046/j.1525-1497.1998.00027.x

Katz P. Providing feedback. Gastrointest Endosc Clin N Am 5(2):347-55; Apr 1995.

Kilminster S, Cottrell D, Grant J & Jolly B. AMEE Guide No. 27: Effective educational and clinical supervision. Medical Teacher 2007; 20:2-19.

Kogan J. How to evaluate and give feedback. In, L.W. Roberts (ed.), The Academic Medicine Handbook: A Guide to Achievement and Fulfillment for Academic Faculty. Springer:New York, pp. 91-101; 2013. DOI 10.1007/978-1-4614-5693-3_11.

Lucas J & James S. Providing Difficult Feedback: TIPS for the Problem Learner. Fam Med 35(8):544-6; 2003.

McDonald, B. & Boud, D. (2003) The impact of self-assessment on achievement: the effects of self-assessment training on performance in external examinations, Assessment in Education, 10(2), 209–220.

Nicol DJ & Macfarlane-Dick D. Formative assessment and self-regulated learning: a model and seven principles of good feedback practice, Studies in Higher Education, 31:2, 199-218; 2006. Accessed at: http://dx.doi.org/10.1080/03075070600572090.

Schultz et al. Medical Students' and Residents' preferred site characteristics and preceptor behaviours for learning in the ambula-

tory setting: a cross-sectional survey. BMC Medical Education, 4:12; 2004.

Schute V. Focus on Formative Feedback. Review of Educational Research 2008 78: 153; accessed online at http://rer.sagepub.com/content/78/1/153.

Sousa A et al. Better data for teachers, better data for residents, better patient care: college-wide assessment at Michigan State University's College of Human Medicine. Medical Education Online, 16: 5926; 2011.

Vaughn L et al. The Problem Resident. Teaching and Learning in Medicine. 10(4), 217-222;

Weiss Roberts L (Editor). The Academic Medicine Handbook: A Guide to Achievement and Fulfillment for Academic Faculty. Springer:NY; 2013.

Wood B. Feedback: A Key Feature of Medical Training. Radiology 215:1 17-19; Apr 2000.

Yorke, M (2003) Formative assessment in higher education: moves towards theory and the enhancement of pedagogic practice, Higher Education, 45(4), 477–501.

Communication, Discourse & Facework

Copland F. Negotiating face in feedback conferences: A linguistic ethnographic analysis. *Journal of Pragmatics 43*: 3832–3843; 2011.

Goffman E. On facework *Psychiatry*, *18*:213-131; 1955.

Goffman E. The presentation of self in everyday life. NY:Doubleday; 1959.

Kern Sujin MK, Lee S, Aytug ZG, Brett JM. Bridging social distance in inter-cultural negotiations: "you" and the bi-cultural negotiator. *International Journal of Conflict Management, 23*(2), pp. 173 – 191; 2012.

Kofman F. Authentic Communication: Transforming Difficult Conversations in the Workplace; 2014.

Roberts C, Wass V, Jones R, Sarangi S, GillettA. A discourse analysis study of 'good' and 'poor' communication in an OSCE: A proposed new framework for teaching students. Med Educ. 2003;37:192–201.

Shadle CC & Meyer JL. Communication Case Studies: Building Interpersonal Skills in the Veterinary Practice. 2014.

Slatkin AA. Communication in Crisis and Hostage Negotiations: Practical Communication; 2012.

Woodward-Kron R. Learner medical discourse and intercultural clinical communication: Towards a contextually informed teaching framework. In: Solly M, ed. Verbal/Visual Narrative Texts in Higher Education. Zurich, Switzerland: Peter Lang; 2008.

Educational Frameworks

Laverick C. B-D-A Strategy: Reinventing the Wheel Can Be a Good Thing. Journal of Adolescent & Adult Literacy 46(2) (October), pp. 144-147; 2002.

Pangaro LN. A Shared Professional Framework for Anatomy and Clinical Clerkship. Clinical Anatomy 19:419–428; 2006.

Pangaro LN. A New Vocabulary and Other Innovations for Improving Descriptive In-Training Evaluations. *Academic Medicine 74*:11 (November); 1999.

Plack MM & Santasier A. Reflective Practice: A Model for Facilitating Critical Thinking Skills Within an Integrative Case Study Class-room Experience. Method-Model Presentation in, *Journal of Physical Therapy Education, 18*(1); 2004.

Nicol, D. J. & Boyle, J. T. (2003) Peer instruction versus class-wide discussion in large classes: a comparison of two interaction methods in the wired classroom, Studies in Higher Education, 28(4), 457–473.

Nicol, D. J. (1997) Research on learning and higher education teaching, UCoSDA Briefing Paper 45 (Sheffield, Universities and Colleges Staff Development Agency).

Plack MM & Greenberg L. The Reflective Practitioner: Reaching for Excellence in Practice. *Pediatrics 116*(6), pp. 1546-1552 (doi: 10.1542/peds.2005-0209); 2005*.

Schön D. The reflective practitioner: How professionals think in action. NY:Basic Books; 1983

Vacca RT and Vacca JL. Content Area Reading: Literacy and Learning Across the Curriculum. Boston: Pearson Publishers; 2005 (now in its 13th edition).

Zhang L & Sternberg RJ. A Threefold Model of Intellectual Styles. *Educational Psychology Review, 17(*1), March 2005.

Metacognition And Self-regulated Learning

Joost Meijer, Marcel V. J. Veenman & Bernadette H. A. M. van Hout-Wolters (2006): Metacognitive activities in text-studying and problem-solving: Development of a taxonomy, Educational Research and Evaluation: An International Journal on Theory and Practice, 12:3, 209-237. Access at: http://dx.doi.org/10.1080/13803610500479991.

Palinscar, A. S. (1998) Social constructivist perspectives on teaching and learning, Annual Review of Psychology, 49, 345–375.

Pintrich, P. R. & Zusho, A. (2002) Student motivation and self-regulated learning in the college classroom, in: J. C. Smart & W.G. Tierney (Eds) Higher Education: handbook of theory and research (vol. XVII) (New York, Agathon Press).

Pintrich, P. R. (1995) Understanding self-regulated learning (San Francisco, CA, Jossey-Bass).

Zimmerman, B. J. & Schunk, D. H. (2004) Self-regulating intellectual processes and outcomes: a social cognitive perspective, in D. Y. Dai & R. J. Sternberg (Eds) Motivation, emotion and cognition (Mahwah, NJ, Lawrence Erlbaum Associates).

Glossary

Click the paperclip, above, to view the glossary, which may also be used as a "study guide".

Resources

Key Points

1. **The FID website** contains a wide variety of resources for learning more about educational strategies for teaching in non-clinical and clinical settings.
2. **You may download** from the FID site several teaching guides on topics such as giving constructive feedback, applying the B-D-A and RIME frameworks to teaching, and providing constructive feedback.
3. **FID Teaching Guides** are listed in this section with hyperlinks to download them directly from the FID website.
4. **There are additional, scholarly references** listed in Section 2.

Section Overview

This section contains additional resources for learning more about feedback and strategies for incorporating feedback in the teaching/learning process.

The FID Website

The FID website contains a wide variety of resources for learning more about educational strategies for teaching in non-clinical and clinical settings.

You may download from the FID site several teaching guides on topics such as giving constructive feedback, applying the B-D-A and RIME frameworks to teaching, and providing constructive feedback.

FID Teaching Guides

The guides below provide graphics and summary explanations of approaches to teaching and assessment as well as advice on how to employ concrete strategies for teaching and offering formative feedback to undergraduate medical students.

You may view or download the following Teaching Guides:

- Constructive Feedback Essentials[1]

- RIME Framework (Reporter-Interpreter-Manager-Educator) Framework[1]
- Educational Strategies for Clinical Settings, employing the combined B-D-A & RIME Frameworks to establish expectations and provide constructive feedback[1]
- How to Formulate Effective Questions for Teaching [1]
- Microskills Card (2014 Edition)[1]
- Inquiry-based Teaching Strategies[1]
- Socratic Questions[1]
- Assessment & Reflective Teaching[1]
- Classroom Assessment Techniques to Assess and Guide Student Performance[2]

More About...

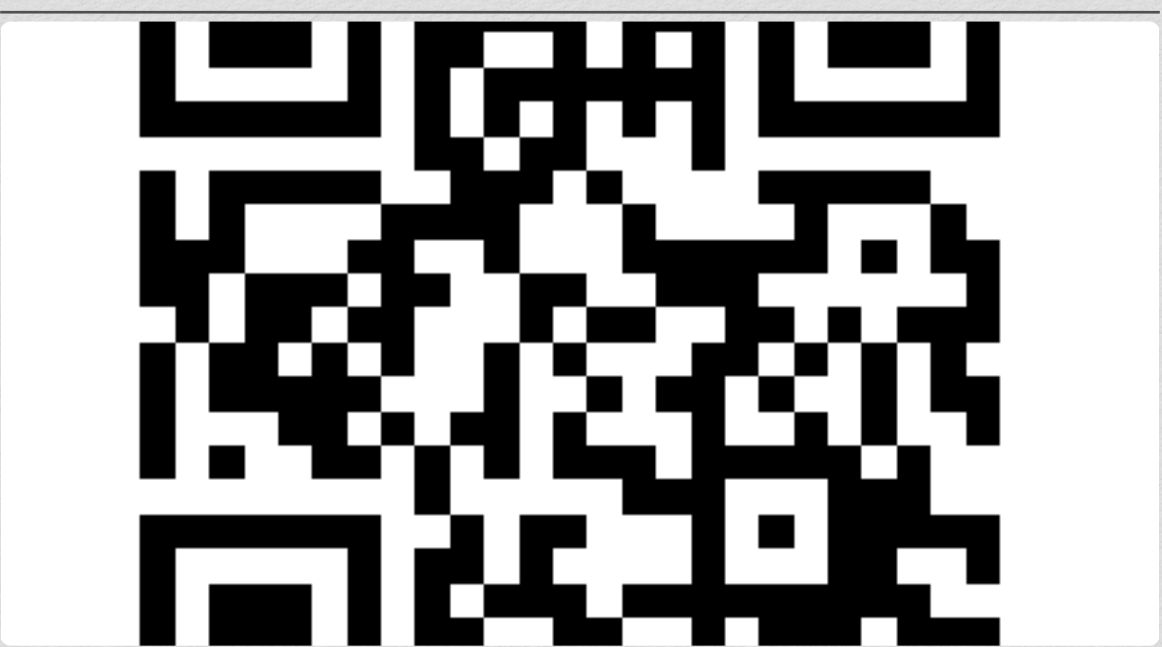
★The B-D-A Framework

★Pangaro's RIME Framework

★Inquiry-based Teaching and Learning

- Mapping the ACGME Competencies to the RIME Framework.
  Academic Medicine 87(12): 1781; 2012.

Figure 6.1 The FID Website QR Code



Use a scanner app on your iPad, iPhone or smart phone or tablet to scan the code above. It will take you to the faculty instructional development website with additional resources for clinical educators.

Sources Of Cited Resources

[1] Karen Spear Ellinwood, PhD, JD, EdS, Director, Faculty instructional development, Office of Learner Education, The University of Arizona College of Medicine, Tucson campus.

[2] Susan Ellis, MA, EdS, Program Manager, Curriculum and Assessment, Office of Learner Education, The University of Arizona College of Medicine, Tucson campus.

Gallery 6.1 Preview Teaching Guides on Constructive Feedback Essentials

As Educators

Constructive Feedback Essentials

Evaluation or Feedback?

Evaluation tells the learner how well or poorly they performed.

- Great job!
- Needs improvement.

Feedback tells the learner why you think they did such a great job or need improvement. In other words feedback should always be constructive – helping the learner to achieve goals and learning objectives.

Find more resources for clinical educators online!
FID.medicine.arizona.edu

1) Invite self-assessment as part of a feedback *conversation.*

Engage the learner in a conversation about their development rather than simply telling them how they are doing. To obtain a baseline for providing formative feedback, ask the student to describe what they did well and what they found particularly challenging or would like to improve.

2) Describe relevant, observable behaviors.

Describe *relevant, observable behaviors* to help the learner understand the specific knowledge, skills or attitudes that motivate your feedback.

3) Include corrective *and* complimentary comments.

Learners benefit from knowing what they did well and what they need to improve. Providing a rationale (above) transforms a compliment or correction into constructive (helpful) feedback.

4) Provide strategic guidance.

Discuss resources and opportunities that may support the learner's further development and specifically to address

Constructive Compliment

You've demonstrated a good habit in seeking clarification of medical knowledge or procedural issues during case presentations. Today, for example, you asked for clarification of sepsis criteria when presenting on the hypertensive, febrile patient.

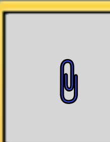
Constructive Correction

Your case presentations tend to start with a complete history of the present illness. When we present cases, we begin with a short statement, a one-liner, describing the reason for the patient's visit.

Guidance

We use a guide that outlines our case presentation format. It might help you to use this while presenting or review it just before you present. I can give you feedback after you've had a chance to present using the guide. And, please continue to contribute to the team discussions. We often learn by thinking things through together.

Learn more about The UA



Glossary

This is a Glossary of terms and key concepts used in this course. The FIND TERM button will open the Advanced Search feature in your Adobe application. Blue underlines indicate a link to another Glossary entry.

Actionable

Actionable statements describe relevant, observable behaviors the recipient could act upon.

Related Glossary Terms

Constructive compliments, Constructive correction, Guidance, Relevant, observable behaviors

---

Index Find Term

Chapter 3 - Reflective Feedback Conversations

Constructive compliments

This term refers to affirmations of behavior, statements or practices that were within or beyond established expectations for performance. Literature may refer to such comments as **positive reinforcement**. The import of such comments is to tell the medical student that they performed well, and provide sufficient description of specific behaviors relevant to demonstrating good or successful performance according to some *established professional standard* that the medical student would be readily capable of reproducing such behavior with the aim of continuing success.

Related Glossary Terms

Actionable, Constructive correction, Feedback, Guidance

Index Find Term

Chapter 3 - Reflective Feedback Conversations

Constructive correction

Correction. This term refers to comments that inform the medical student that specific behaviors, statements or practices do not fall within established expectations or standards of professional practice. In this course, correction is referred to as ***constructive correction,*** which describes relevant, specific behaviors that demonstrate the medical student's performance does <u>not</u> meet expectations according some *established professional standard*.

Related Glossary Terms

Actionable, Constructive compliments, Feedback, Guidance

Index Find Term

EPAs

EPA stands for Entrustable Professional Activities. ACGME established a set of 12 core EPAs that all medical students would need to be able to do upon entering residency. You may find these by going to the ACGME site at https://members.aamc.org/eweb/upload/Core%20EPA%20Curriculum%20Dev%20Guide.pdf.

Related Glossary Terms

Established professional standard

Index Find Term

Established professional standard

Established professional standard. A professional standard may be established by the specialty's milestones, the institution's, department's or program's learning objectives, or the resident educator in a given situation in keeping with one of those professional sources. Establishing these expectations or standards involves communicating them to the medical student and ensuring the medical student understands the expectations or standards.

Related Glossary Terms

EPAs, Evaluation, Feedback, Relevant, observable behaviors

Index Find Term

Evaluation

Evaluation tells the medical student whether they performed well or poorly, or somewhere in between. It consists of the opinion of the evaluator. The evaluator might be offering evaluative remarks informally or as part of a formal evaluation process. While evaluation consists of opinion, such evaluation, to be fair, should be based upon evidence (relevant, observable behaviors) and established professional standards for performance.

Related Glossary Terms

Established professional standard, Feedback

Index Find Term

Chapter 2 - Is it Feedback or Evaluation?

External Feedback

External feedback is feedback from a source other than self-assessment.

See Nicol & McFarlane-Dick, 2006.

Related Glossary Terms

Index Find Term

Feedback

Feedback tells the medical student why the evaluator concluded that the performance was good or poor. Thus, feedback should describe relevant, observable behaviors and explain why these constitute sufficient performance (or not).

Feedback articulates the foundation for evaluative opinion.

Related Glossary Terms

Constructive compliments, Constructive correction, Established professional standard, Evaluation, Guidance, Invitation to self-assess performance, Relevant, observable behaviors

---

Index Find Term

Chapter 2 - Is it Feedback or Evaluation?

Guidance

Guidance. This term refers to advice for improvement or guiding a discussion or the medical student's suggestions for change in practice or behavior to address the cited behaviors. Guidance may consist of modeling the expected behavior, skill or practice.

Related Glossary Terms

Actionable, Constructive compliments, Constructive correction, Feedback, Relevant, observable behaviors

Index Find Term

Influential Factors

Awareness of the factors that could affect the course and outcome of the feedback procu ess is the first step to considering how to address them.

The following are some influential factors in the feedback process:

- **Communication skills** - the respective communication skills and styles of the instructor and learner;
- **Context** - the context or situation surrounding the student's behavior, patient encoun-ter or other circumstance (including the interests at stake for the student, resident educator, patient or others);
- **Delivery** - manner and tone of delivery.
- **Hierarchy** - the participants' relative hierarchical position as well as the instructor's hierarchical position (is this someone from whom t his medical studentwill accept critical feedback);
- **History** - Relationship between the resident educator and the medical student, includ- ing their interpersonal dynamics and shared history or lack thereof;
- **Receptivity** of the participants to corrective remarks; and
- **Timing** - for example, is it proximal to the event.

Engaging in face-to-face communication requires awareness of self and other. It involves dynamics of interpersonal communication. When giving feedback, then, it also helps to consider the following:

- The participants' expectations for the conversation;
- Whether the participants abide by those expectations during the encounter;
- Whether participants address any perceived violations of those expectations;
- The participants' role in the broader context or group (e.g., residency program, depart- ment; division); and
- Any other factors that would tend to affect the position, power or authority to speak or address issues of performance or the relationship itself.

Related Glossary Terms

Index Find Term

Invitation to self-assess performance

Invitation to self-assess performance. This term refers to any statement or request that elicits from the medical student their assessment of performance on a specific occasion or occasions.

Related Glossary Terms

Feedback

Index Find Term

Microskills for teaching

The microskills model is aimed at helping busy clinicians who are teaching at the bedside and have little time to prepare formally for teaching. The five steps remind clinician educators to offer both positive reinforcement and correction, as needed. While there is no specific emphasis on sequence, the order of these five components of bedside teaching has been repeatedly represented as ending with correction.

The five steps or components are:

1) Get a commitment

2) Probe for (supporting) evidence

3) Teach a general rule

4) Reinforce what was right

5) Correct (suggest or model correction)

Source: Neher et al. 1992

In 2012, the author adapted the Microskills approach to incorporate the reflective feedback conversation. The purpose was to teach medical students how to implement the final two steps of the Microskills approach (Reinforce what is right; Correct). This resulted in the Microskills 5 Plus 5! approach that added the following 5 steps:

1. Be timely and respectful

2. Be explicit about giving feedback

3. Describe relevant observable behaviors

4. Invite self-assessment and reflection for improvement

5. Suggest or model corrective action

This adaptation was intended to reflect the essential components of effective or constructive feedback described in the literature.

Related Glossary Terms

Relevant, observable behaviors

This term refers to specific examples of behavior, statements or practices that can be observed, and not to the inferences

Related Glossary Terms

Actionable, Established professional standard, Feedback, Guidance

Index Find Term