“Sometimes, I just don’t know if I’m getting through or not…”

Principles of framing and delivering effective feedback to pharmacy residents

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Consider the following situations:

- A thoroughly likable but hopelessly disorganized resident: patients love him, RNs/MDs find him charming but he's just too scattered for your liking…
- An overly-intense and self-doubting resident, who constantly questions her/his competence despite being almost always correct…
- A resident who is simply going through the motions: unclear of why she/he is doing this program other than filling in time before having to get a real job…

Which of these situations would you personally find most difficult to manage?

a) Thoroughly-likable but hopelessly disorganized resident
b) Overly-intense and self doubting resident
c) Resident who is simply going through the motions

Objectives

Upon completion of this webinar, you will be able to:

a) Describe principles of effective feedback – development and delivery
b) Evaluate the quality of feedback
c) Discuss strategies for delivering feedback in difficult or awkward situations
d) Reflect upon personal barriers to feedback delivery and identify opportunities for self-improvement

What is the purpose of a pharmacy residency?

Professional development:

- Pharmacotherapy
- Patient care/medication therapy management
- Administrative/managerial competencies

Personal development:

- Self-efficacy/self-confidence
- Conflict management/negotiation
- Time/resource management
- Pride in one's profession

The residency teaching model

- Built upon experience in medical education
- Flows from traditional apprenticeship model
- IMMERSION: in an authentic clinical environment
- OBSERVATION: of role models
- REHEARSAL: in safe spaces, with feedback
- PERFORMANCE: in real spaces, with evaluation

Feedback vs Evaluation

- No consensus in terms of definitions
- For the purposes of this presentation, will use the term "**feedback**" to mean "Formative Assessment" and "**evaluation**" to mean "Summative Assessment"
- *Formative* = informing, low-stakes, aimed at improvement, not judgment
- *Summative* = evaluative, judgmental, aimed at benchmarking/ranking or rating

Do you clearly and explicitly let residents know when they are being evaluated vs. when you are simply providing feedback?

a) Yes
b) No

Why is feedback important?

- Need to rehearse before one performs
- Feedback, when provided constructively, enhances performance improvement
- Self-assessment is notoriously unreliable amongst novices: "they don't know what they don't know"…instead, must rely upon external observation and guidance from a trusted role model

Pendleton's Rules

I. Check that the learner actually wants feedback
II. Let the learner give general comments to the material being assessed
III. Learner states what was done well
IV. Observer states what was done well
V. Learner states what could be improved
VI. Observer states HOW it could be improved
VII. Learner + observer agree on an 'action plan'

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

Translating to the pharmacy residency context

Three key questions to prompt reflection and discussion following an interaction/event:

1. What did you do well?
2. What could you have done better?
3. What did you learn about this experience for the next time?

How does this “work”?

- Built upon model of *reflective practice*: sustainable quality improvement can only occur through frank self-appraisal
- Utilizes non-judgmental *inquiry model*: instead of “telling” you are “asking”
- Keeps learner thinking, talking, and actively *engaged* in process rather than passively listening and simply agreeing

Nice in theory but….

Problem	Possible alternatives
Inaccurate self-assessment	- ask learner for more detailed "evidence" to support self-assessment - ask learner to consider external stakeholders' perspectives
Disinterest/lack of inclination to self-reflect	- allow teacher to become focus of assessment - model self-reflection for learner
Sophisticated ability to game the system	- follow-up to ensure step #3 actually occurs - document rather than simply discuss
Too much wrong – where do I even start?	- prioritize "low hanging fruit" - ensure focus is to address no more than 2-3 substantive issues

Case #1

You have observed a student take a medication history. The student is a "smooth operator": fluent, pleasant and charming, but clearly wasn't prepared, forgot key questions to ask, and seemed more focused on building a rapport with the patient than eliciting important information. In response to Pendleton Questions, you hear:

1. "The patient really connected well with me";
2. "I'd focus less on the questions and more on making her feel comfortable"
3. "I'd book more time with the patient since she clearly liked speaking with me"

What would you do, as this resident's preceptor?

a) Explicitly disagree with what the resident has just said
b) Ignore what the resident said and simply provide feedback
c) Ask the resident to provide evidence for assertions
d) Seek out a colleague to provide a second voice/opinion

Case #1

Alternative redirecting statements:

- "How do you think the rest of the team will benefit from this interaction with the patient?"
- "You've seen me do this before…what do I do differently that you think works well? That doesn't work so well?"
- "It seems that some information might have been missed during that interview (give specific examples). How might this affect the treatment the patient is now going to receive based on your documentation alone?"

Case #1

The Feedback Sandwich:

"You're right, the patient really seemed to connect well with you…and if that were the only objective of the med history that'd be great. I am worried that you missed asking about allergies and responses and that's critical since the patient will need antibiotics today and now we will need to re-interview her/him to get this information. So remembering to be thorough in your interview while keeping up the great work you did in building this relationship would be ideal."

General principles for delivery of effective feedback

- Only give feedback when desired and/or expected by the learner
- Feedback should be close in time to the event
- Praise in public, correct in private
- Stay in the “here and now”: don’t bring up previous mistakes or old concerns
- Focus on behaviours that can actually be changed, not personality traits

General principles for delivery of effective feedback

- For every statement provide specific evidence from what you actually observed
- Use “I” statements to describe your experience/response to the observed behaviour (“when you said…I thought….”)
- Avoid giving negative feedback without also being able to provide a supportive alternative
- Congruence between verbal and non-verbal messaging
- Express genuine interest in student’s development…this should not be a chore

Alignment with competency-based residency program's objectives

- Educational focus of residency has shifted away from strict knowledge/fact acquisition and duration of training towards attainment of behavioural outcomes
- Leaners must reach specific milestones as they develop competencies
- Detailed and prompt feedback on performance + opportunities to improve helps to achieve milestones

Feedback: a learner's perspective

Medical residents:

- Feedback, when given effectively is single most valuable event in helping them to gauge performance
- Feedback given too infrequently or unexpectedly is counterproductive
- Feedback to reinforce positives also necessary
- Wrong place/space for feedback is damaging
- Distracted or disinterested feedback is irritating
- Teachers with minimal experience are simply hard to believe/not credible
- Translating observations into specific, non-judgmental, constructive feedback is difficult for most preceptors
- General feedback isn't worth the effort
- Hierarchical culture of medicine promotes one-way lecture, not a two way conversation learners desire
- Confusion between "evaluation" and "feedback" especially when the preceptor is the same person!

Did any of the medical resident's perspectives presented on the previous slide surprise you?

a) Yes
b) No

Case #2

Your resident is clever and technically skilled but displays some peculiar interpersonal mannerisms; frankly, you're concerned that he simply doesn't respect women's opinions despite appearing to be polite and attentive. You are not sure if this can be "excused" culturally or for another reason, and you are concerned that this attitude will be problematic within a female dominated profession and health care context.

Alternatives

	Unconscious incompetence	Conscious incompetence	Conscious competence	Unconscious competence
Learner	Unaware of shortcomings; "don't know what I don't know"	Aware of shortcomings but doesn't have skills to actually correct them	Demonstrates competence in a "faked", unnatural, or overly thought-out way	Formulaic or routinized approach to problems
Strategies for feedback	Focus on raising awareness of issue NOT on solving problem itself	Develop and refine specific skills – address "low hanging fruit" first to build confidence	Gradual building of complexities Consistent positive reinforcement to build confidence	"Talk aloud" to focus student's attention on processes that underlie behaviours and reduce automaticity

Case #2

Managing unconscious incompetence:

- Multiple stakeholder perspectives to surface issues; one person alone can't "break the bad news"
- Focus is not yet on "fixing" a problem but on helping learner realize there is an issue
- Role-playing, case studies, hypothetical discussions in safe settings as a way of illustrating issues

Case #2

- Interpersonal challenges most frequently caused by unconscious incompetence: objective is to give learner an opportunity to see/hear him/herself in action (e.g. video/audio taping, testimonials from others in a team/patients, etc.)
- Shift from unconsciousness to consciousness may be very painful, accompanied by defensiveness, denial etc.: develop strategies to manage this in advance rather than simply respond in real time
- Ensure you have abundant examples of positive behaviours to support emotional responses

"12 tips for giving feedback effectively in the clinical environment"

I. Establish a respectful learning environment
II. Communicate goals/objectives of feedback
III. Base feedback only on direct observation, not hearsay
IV. Make feedback timely, predictable, and a regular occurrence in your relationship
V. Begin with learner self-assessment
VI. Reinforce exemplary behaviours and highlight necessary corrections

Rahmani S and Krackov S (2012). Twelve tips for giving feedback effectively in the clinical environment. Medical Teacher 34:787-791.

"12 tips for giving feedback effectively in the clinical environment"

VII. Use specific and neutral language to focus on performance

VIII. Confirm learning's understanding and acceptance

IX. Conclude with an action plan

X. Reflect on your own feedback skills

XI. Create staff development opportunities

XII. Make feedback a part of your organizational culture

Case #3

Your resident is a clever, organized and dedicated learner but is frequently her own worst enemy: she seems to go out of her way to find flaws with herself despite abundant evidence (and comments) from staff and MDs about what a great job she is doing. While you appreciate a degree of modesty and a humble attitude, you are also getting a bit tired of constantly having to “ego-stroke”.

What would you do, as the resident's preceptor?

a) Provide supportive feedback on professional issues
b) Attempt to get to know the resident better as a person
c) Determine what other/psychological issues may be present
d) Utilize peer mechanisms to illustrate quality of work
e) I really don't know

Case #3

- Few of us are psychologist or social workers: we cannot change core personality traits that have formed over decades
- Clarity around understanding of remit is essential: preceptors are teachers, not (necessarily) therapists
- Excessively inappropriately low self-esteem may require professional referral or support rather than well-intentioned “coaching”

Case #3

- For a less dramatic situation, feedback to bolster confidence may be linked to accurate self-appraisal
- *"They don't know what they don't know"* effect: "A" and "D" students have the least accurate self-appraisal skills: "B" students have the most accurate
- Lack of understanding of criteria and their interpretation may be an issue: "scaffolding" early on may be useful technique
- Forcing positive feedback from student may be challenging but helpful
- 360-degree process (if feasible) may be more useful than individual/preceptor-only feedback

Summary/Conclusion

- Feedback is integral to the teaching and learning process
- It is a skill that must be learned and nurtured
- It is a communication dynamic that can't be forced or faked
- Organizational/cultural support is essential
- When it's done right…it is transformative

Some additional readings

Bing-You RG and Trowbridge RI (2009). Why medical educators may be failing at feedback. JAMA 302:1330-1331.

Cantillon P and Sargent J (2008). Giving feedback in clinical setting. BMJ 337:a1961.

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Austin Z (2010). Educating pharmacists: a guide for mentors and preceptors of international pharmacy graduates. Toronto: University of Toronto Press