Feedback: The Need for Meaningful Conversations

Christopher J. Harrison, MB ChB, MSc, FRCGP

Everyone seems to be grappling with feedback these days. When it works well, it can be extremely powerful, 1 of our most powerful tools for changing future performance. Yet it often fails to reach its potential.

Why is that?

Supervisors find feedback to be a complex process.[1] On the one hand, they want to improve learners' future performance. On the other, they want to build learners' confidence and fear being perceived as unkind. These aims frequently are in conflict. Too often, we have thought of feedback as a unidirectional monologue. However, the importance of creating a dialogue between supervisor and learner is increasingly recognized.[2]

In an interesting article in this issue of the *Journal of Graduate Medical Education*, Sargeant and colleagues[3] build on the emerging evidence regarding effective feedback. They have evaluated their theory-informed R2C2 feedback model in a real-world setting. R2C2 stands for rapport and **R**elationship building, exploring **R**eactions to feedback, exploring feedback **C**ontent, and **C**oaching for change. They found that supervisors used all 4 phases of the model and valued the structured format. Supervisors also made good use of open questions to explore residents' perspectives, which promoted reflection, and thus, residents felt engaged in the feedback discussions. Both supervisors and residents found the coaching phase the most useful part, as it encouraged collaboration in order to develop specific plans for change.

This study made me reflect on the comparisons between feedback and other communication skills, such as breaking bad news. Numerous frameworks exist to guide clinicians and students who are learning to communicate well. The R2C2 model has a number of similarities with the SPIKES model for breaking bad news, which has been shown to be helpful for improving clinicians' confidence in this area.[4] As with breaking bad news, a feedback discussion needs to be handled carefully. Both models emphasize the benefits of careful preparation beforehand, the need to build rapport and empathize, and then to explore reactions to the information that has been shared. Finally, participants collectively agree to an action plan. When a breaking bad news interaction goes well, it is because it's a meaningful conversation rather than a hastily delivered monologue from a clinician who is afraid to be drawn into difficult areas. Sargeant et al[3] describe how supervisors found the R2C2 framework helpful as it led to richer, deeper conversations while discouraging brief discussions just to check off the feedback box. Supervisors' busy schedules make it challenging to carve out enough minutes in the day for feedback, but, as with breaking bad news, it is time well spent.

Therefore, it is very likely that using this model will help supervisors to be more confident in having feedback conversations with their residents. In particular, it will be helpful if supervisors stop thinking of themselves as deliverers of feedback and, instead, view themselves as participants in a conversation. Of course, problems with feedback do not always lie with the supervisor. Learners are not necessarily always receptive to the feedback, as feedback that is not aligned with their own self-assessment risks being ignored.[5] Residents also need to be encouraged to take an active part in the feedback conversation. This is an area that has not received sufficient scrutiny until recently and is a fruitful topic for future research.

It would, however, be very naïve to assume that a single meaningful feedback conversation is all that is needed to send a resident off on the right track. Primary care physicians have long recognized the importance of a long-term, therapeutic relationship between a doctor and a patient.[6] Continuity of this relationship over many years helps in numerous ways. Trust takes time to develop between a clinician and a patient. As a result of this trust, physicians can safely challenge inappropriate patient expectations without harming the doctor-patient relationship. Similarly, the importance of long-term mentoring in feedback is receiving increasing attention. A recent study[7] demonstrated that long-term mentors could help medical learners to be more receptive to feedback as mentors were able to safely challenge learners' flawed self-assessments.

Sargeant and colleagues[3] rightly highlight the importance of the coaching stage in order to bring about meaningful change. For coaching to work, we need to recognize the importance of developing a culture and climate that is receptive to feedback.[8] Medicine as a field struggles with this concept.

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Typically, the supervisor is both assessor and feedback coach. The relationship between these 2 roles is often an uneasy one.[9] Although this is how medicine's culture has evolved, it does not necessarily always have to be this way.

Music and sports, for example, have very different coaching cultures. Typically, music teachers and sports coaches work with their trainees over many years. The continuity and mutual trust that develops helps push the trainee to ever-higher levels of performance. Moreover, the trainee seems more receptive to critically constructive feedback than is often the case in medicine.[10] However, this analogy can only be stretched so far. Music teachers and sports coaches are only accountable to their students, whereas medical supervisors are also accountable to patients. Excellent clinical care still needs to take place at the same time as meaningful feedback, and the urgency and importance of the former can easily overwhelm our attempts to attend properly to the latter. As Sargeant et al[3] point out, supervisors' busy clinical schedules was a limiting factor for recruitment into the study.

Just as relationship continuity is challenging to achieve in clinical practice,[6] achieving it in a residency setting is equally fraught with difficulty, as Sargeant and colleagues[3] highlight. However, personal experience in a clinical setting tells us that it is 1 of the most rewarding aspects of clinical care. Rearranging residency programs to improve supervisor-resident continuity will require a paradigm shift in thinking. However, the benefits are likely to be worth it. Both supervisors and residents will be likely to find the learning and feedback process much more meaningful. More importantly, this change should benefit patients as they ultimately stand to gain the most from supervisors and residents engaging more effectively with feedback.

References

1. Kogan JR, Conforti LN, Bernabeo EC, et al. Faculty staff perceptions of feedback to residents after direct observation of clinical skills. *Med Educ*. 2012;46(2):201–215.
2. Telio S, Ajjawi R, Regehr G. The "educational alliance" as a framework for reconceptualizing feedback in medical education. *Acad Med*. 2015;90(5):609–614.
3. Sargeant J, Mann K, Manos S, et al. R2C2 in action: testing an evidence-based model to facilitate feedback and coaching in residency. *J Grad Med Educ*. 2017;9(2):165–170.
4. Baile WF, Buckman R, Lenzi R, et al. SPIKES—a six-step protocol for delivering bad news: application to the patient with cancer. *Oncologist*. 2000;5(4):302–311.
5. Mann K, van der Vleuten C, Eva K, et al. Tensions in informed self-assessment: how the desire for feedback and reticence to collect and use it can conflict. *Acad Med*. 2011;86(9):1120–1127.
6. Hall MN. Continuity: a central principle of primary care. *J Grad Med Educ*. 2016;8(4):615–616.
7. Harrison CJ, Könings KD, Dannefer EF, et al. Factors influencing students' receptivity to formative feedback emerging from different assessment cultures. *Perspect Med Educ*. 2016;5(5):276–284.
8. Ramani S, Post SE, Könings K, et al. "It's just not the culture": a qualitative study exploring residents' perceptions of the impact of institutional culture on feedback. *Teach Learn Med*. 2016 Dec 21:1–9. Epub ahead of print.
9. Watling C. The uneasy alliance of assessment and feedback. *Perspect Med Educ*. 2016;5(5):262–264.
10. Watling C, Driessen E, van der Vleuten CP, et al. Learning culture and feedback: an international study of medical athletes and musicians. *Med Educ*. 2014;48(7):713–723.

Christopher J. Harrison, MB ChB, MSc, FRCGP, is Senior Lecturer in Medical Education, Keele University School of Medicine, Staffordshire, United Kingdom.

Corresponding author: Christopher J. Harrison, MB ChB, MSc, FRCGP, Keele University School of Medicine, David Weatherall Building, Room 1.25, Staffordshire ST5 5BG United Kingdom, c.j.harrison@keele.ac.uk