# You Get What You Give: Implementing a Resident-Faculty Feedback Loop on an Academic Family Medicine Inpatient Service

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**Learning Objectives:**
On completion of this session, the participants should be able to...

1. Define feedback in a clinical education setting.
2. Name at least three characteristics of effective feedback.
3. Describe the implementation of an interactive, reflective resident feedback process in an academic Family Medicine inpatient service setting.

**What is feedback?**
In clinical medical education, feedback refers to specific information comparing a trainee's observed performance in a given activity to a standard, and it is intended to improve the trainee's future performance[1,2]. Without effective feedback, "mistakes go uncorrected, good performance is not reinforced, and clinical competence is achieved empirically or not at all"[1].

However, feedback is only as good as what is internalized by the learner, so it is important to use principles of effective feedback with resident learners.

**Effective feedback is:**
a) A vital "step in the acquisition of clinical skills" during residency and is essential to practice improvement for residents[1,3], yet many trainees report that feedback is rare or ineffective[1,2].
b) An important step in helping residents achieve the cognitive, affective, and psychomotor or competency objectives of the Family Medicine residency curriculum (i.e. the ACGME Milestones), and can be used for both formative and summative purposes[4]
c) Constructive, timely, specific, and non-evaluative[1-5].
d) Focuses on observable, remediable behaviors, and not personality traits[1,2].
e) Compares behaviors to explicit standards[1,2,5].
f) Interactive.
g) Conducted in a relaxed, private atmosphere, and is limited to a few key points[1,5].

h) Begins with self-assessment and ends with both reflection on feedback, to aid assimilation and acceptance of feedback, and creation of a specific action plan for future improvement[3-5].

**Reasons for Change:**
Our previous inpatient service feedback system consisted of a de-synchronized online evaluation completed by the faculty attending on each resident, after completion of their week on service.

The new system requires a brief face-to-face feedback session between the attending and each resident on service, for the reasons listed below:

a) "Making feedback a regular part of the educational experience encourages the development of expertise"[5], placing residents on the path to success.
b) Face to face feedback allows for feedback to be interactive and meaningful - a place to clarify and ask questions.
c) Encourages reflection.
d) Ensures reciprocal understanding.

**NEW Interactive Feedback Process:**

At our program, we aimed to implement these effective feedback principles into an interactive, reflective resident feedback process on the Wake Forest Family Medicine inpatient service.

a) At the end of each week on service, faculty attending meets with each resident individually for 5-10 minute face-to-face feedback session employing the above principles of effective feedback and using the ACGME Milestones as reference standard.
b) Resident summarizes feedback and enters into MedHub resident evaluation form (see image below in Appendix A) - organized by ACGME Milestones, as well as two open-ended questions that include an action plan based on the feedback received (things I did well, things I plan to work on).
c) Attending reviews final entries to ensure accurate reflection of resident feedback, clarifies any misunderstandings, and submits final feedback form.

**Goals:**
To improve feedback
a) quality (e.g. more actionable, specific items),
b) timeliness, and
c) quantity.

**Results:**

| 2016 | No. of evaluations sent out | No. of evaluations completed on time (within 7 days) | % On Time | No. of evaluations late (past 7 days) | % Late | No. of evaluations incomplete | % Incomplete | No. of Evaluations with comments(on-time&late evals) | % Comments |
|---|---|---|---|---|---|---|---|---|---|
| JULY | 26 | 14 | 54% | 3 | 12% | 9 | 35% | 17 | 100% |
| AUG | 21 | 7 | 33% | 2 | 10% | 12 | 57% | 9 | 100% |
| SEPT | 20 | 4 | 20% | 12 | 60% | 4 | 20% | 15 | 94% |
| OCT | 22 | 8 | 36% | 2 | 9% | 12 | 55% | 10 | 100% |
| NOV | 25 | 2 | 8% | 10 | 40% | 13 | 52% | 12 | 100% |
| DEC | 28 | 0 | 0% | 25 | 89% | 3 | 11% | 21 | 84% |
| TOTAL/6mos. | 142 | 35 | 25% | 54 | 38% | 53 | 37% | 84 | 94% |

| 2017 | No. of evaluations sent out | No. of evaluations completed on time (within 7 days) | % On Time | No. of evaluations late (past 7 days) | % Late | No. of evaluations incomplete | % Incomplete | Evaluations with comments(on-time&late evals) | % Comments |
|---|---|---|---|---|---|---|---|---|---|
| JULY | 25 | 16 | 64% | 9 | 36% | 0 | 0% | 25 | 100% |
| AUG | 21 | 14 | 67% | 7 | 33% | 0 | 0% | 21 | 100% |
| SEPT | 20 | 9 | 45% | 10 | 50% | 1 | 5% | 18 | 95% |
| OCT | 22 | 6 | 27% | 14 | 64% | 2 | 9% | 20 | 100% |
| NOV | 25 | 9 | 36% | 8 | 32% | 8 | 32% | 17 | 100% |
| DEC | 29 | 19 | 66% | 6 | 21% | 4 | 14% | 21 | 84% |
| TOTAL/6mos. | 142 | 73 | 51% | 54 | 38% | 15 | 11% | 122 | 96% |

T- test comparing the means of % on-time evaluations pre- and post-intervention:

| Pre | Post |
|---|---|
| 56 | 60 |
| 14 | 67 |
| 20 | 45 |
| 36 | 27 |
| 8 | 40 |
| 0 | 54 |

P=0.0271, meaning there is a 2.7% chance these results (monthly rate of on-time evals) were obtained by chance.

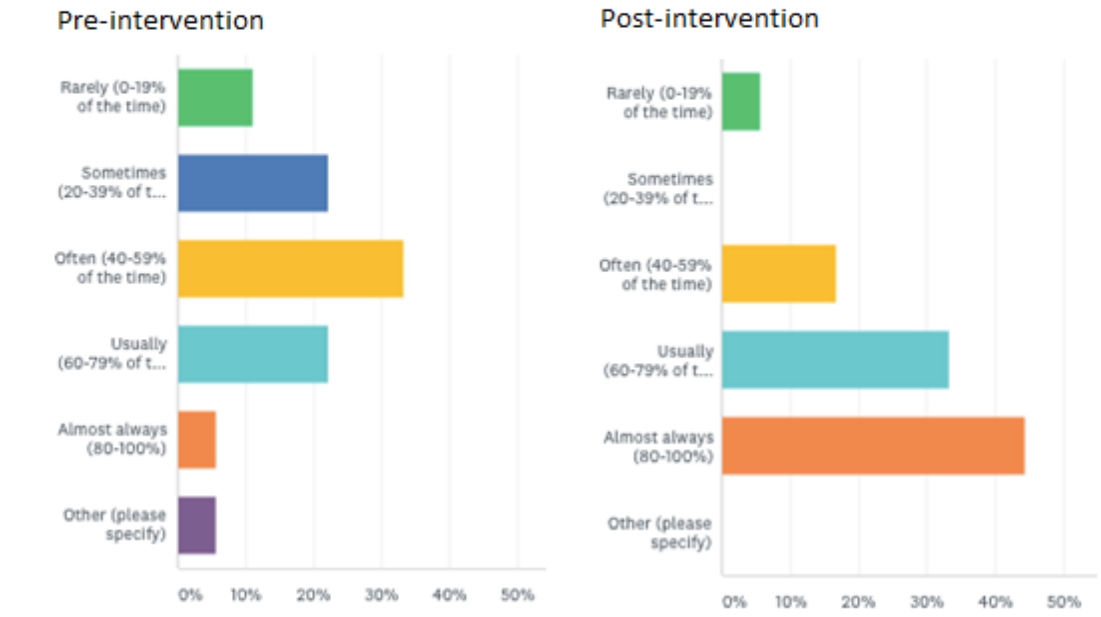
**- Examples of comments from pre- and post-intervention (Knudson)**

**Resident survey results (18/30 response rate for both pre- and post-intervention surveys):**

Q1

How often do you receive face to face feedback from the Family Medicine inpatient service attending at the end of the week?

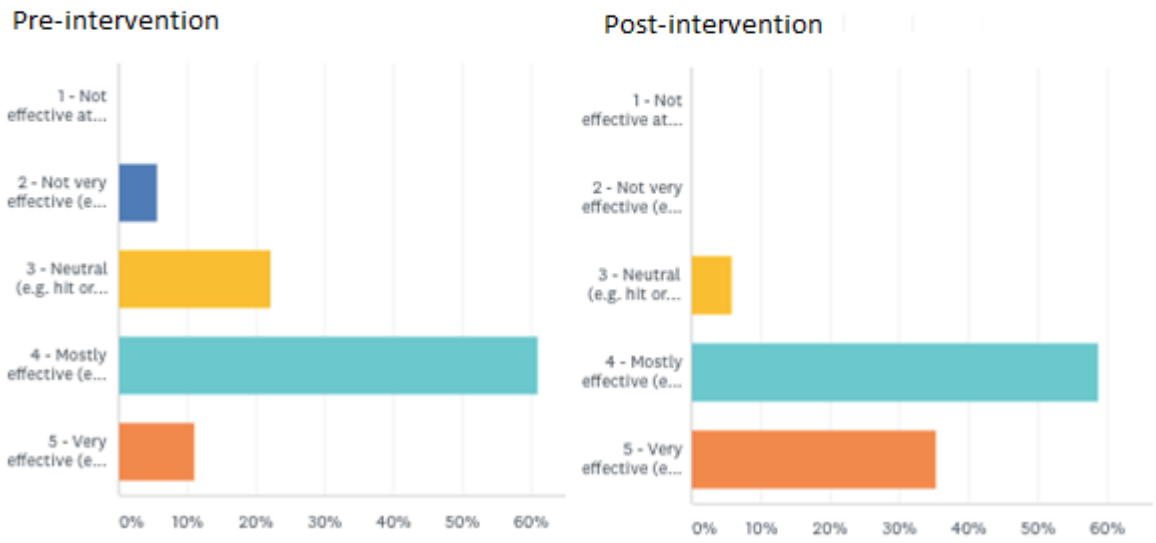
Answered: 18 Skipped: 0




Q2

How effective is the feedback that you receive from the Family Medicine inpatient service attendings?

Answered: 18 Skipped: 0



## Pre-intervention survey comments:

When an attending gives feedback, they take time and it is great. The problem is not all attendings take the time to do this.

6/13/2017 7:04 PM View respondent's answers

When I have received feedback verbally, it is always helpful. I was lucky enough to receive outstanding feedback from an attending at the beginning of my intern year and it changed my outlook and process on inpatient immediately and I just as quickly saw dramatic improvement. This is incredibly valuable and should instituted and made a requirement, but I hope that attendings also take the time to give feedback when they find it most imperative, as there is nothing more helpful than well timed feedback that can be connected to an experience as it is happening or just happened.

6/13/2017 6:51 PM View respondent's answers

## Post-intervention survey comments:

Showing **2** responses

Most effective feedback has been given to me by Dr. Knudson. He takes time to meet with everyone individually and make you reflect on your good traits and those that need work.

1/16/2018 10:35 AM View respondent's answers

Got face to face feedback from attending on days however on nights it was more difficult as I never saw the attending.

1/12/2018 7:04 AM View respondent's answers

## Troubleshooting:

- Rolling out the new process → involved faculty in redesign of evaluation form, did several presentations to faculty and residents regarding the new process prior to rollout
- Obtaining buy-in from faculty and residents → residents generally receptive, faculty incentivized because they get forms completed and they were involved in discussions at multiple faculty meetings
- Finding a quiet place to do feedback during a busy inpatient rotation → tried several locations and eventually found a rarely used conference room

# Appendix A

Preview Form
Printed on Jul 18, 2017

medhub

**Weekly: Inpatient Evaluation (revised 7/2017)**

**Attention Evaluator:** Please complete this evaluation based on your face-to-face feedback session with the resident.

As of Oct. 2014, Family Medicine implemented the ACGME Family Medicine Milestones and changed the scale rating system. You will note that there are five(5) levels of evaluation, each according to the degree of supervision that the resident requires in the skill being evaluated. These five(5) levels of evaluation parallel the "milestones" as defined by the ABIM/ACGME. A simple way to think about them is as follows:

• Level 1: The resident demonstrates milestones expected of a resident who has had **SOME EDUCATION** in family medicine.

• Level 2: The resident is **ADVANCING** and demonstrating additional milestones.

• Level 3: The resident continues to advance and demonstrate additional milestones; the resident consistently demonstrates the **MAJORITY** of milestones targeted for residency.

• Level 4: The resident has advanced so that he or she now substantially demonstrates the milestones targeted for residency. This level is designed as the **"GRADUATION TARGET"**.

• Level 5: The resident has advanced beyond performance targets set for residency and is demonstrating "aspirational" goals which might describe the **PERFORMANCE OF SOMEONE WHO HAS BEEN IN PRACTICE FOR SEVERAL YEARS**. It is expected that **ONLY A FEW EXCEPTIONAL RESIDENTS** will reach this level.

For more information regarding the specifics of the milestones for Family Medicine see the Resources/Documents section of MedHub for further descriptions of Milestones. The document is titled "FM Milestones".

As always, your comments are extremely valuable to provide the most specific feedback possible, and they are particularly valuable to support any ratings of "Level 4 (Graduation Target)" or "Level 5 (Aspirational)" performance, especially for a resident early in training. Additionally, comments related to any ratings of "Has Not Achieved Level 1" are also essential.

**RESIDENT'S RESPONSES BASED ON FACE-TO-FACE FEEDBACK SESSION WITH ATTENDING:**

1. Things I did well: *

2. Things I plan to work on: *

**PATIENT CARE**

| | Has Not Achieved Level 1 | Level 1 | Level 2 | Level 3 | Level 4 (Graduation Target) | Level 5 (Aspirational) | N/A |
|---|---|---|---|---|---|---|---|
| | | ▪ Gathers essential | ▪ Consistently recognizes | ▪ Consistently recognizes | ▪ Coordinates care of acutely ill | ▪ Provides and coordinates | Not Observed |
| Cares for acutely ill or injured patients in urgent and emergent situations and in all settings* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**OVERALL**

Additional faculty comments

* Required fields ◢ Option description (place mouse over field to view)

Reset Form | Submit completed evaluation | Submit

**References:**

1. Ende J. (1983). Feedback in clinical medical education. *The Journal of the American Medical Association,250*(6), 777-781. doi:10.1001/jama.1983.03340060055026.

2. Van De Ridder, J. M., Stokking, K. M., McGaghie, W. C., & Ten Cate, O. T. (2008). What Is Feedback In Clinical Education?. *Medical Education*, 42(2), 189-197.

3. Sargeant, J. M., Mann, K. V., Vleuten, C. P., & Metsemakers, J. F. (2009). Reflection: A Link Between Receiving And Using Assessment Feedback. *Advances in Health Sciences Education*, 14(3), 399-410.

4. Kern, D. E., Thomas, P. A., & Hughes, M. T. (2009). Curriculum development for medical education: a six-step approach. Baltimore, MD: Johns Hopkins University Press.

5. Krackov, S. K. (2013). Giving feedback. In J. A. Dent & R. M. Harden (Eds.), *A practical guide for medical teachers* (4th ed., pp. 322-332). London: Churchill Livingstone/Elsevier.