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Feedback provided by clinical teachers during undergraduate medical training: A Sri Lankan experience

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Abstract

Introduction: Feedback reinforces good practice, identifies deficiencies and directs the learner to narrow the gap between actual and desired performance thus, playing a crucial role in the development of competence in medical training. However, feedback if not carefully handled can result in de-motivation and deterioration in performance.

It is believed that culture plays an important role in the way behaviours are valued and tolerated in educational settings.

Aim: To explore perceptions of Sri Lankan medical graduands on feedback received from teachers during clinical training.

Method: The study was conducted on a single intake of medical graduates after release of final MBBS results, ensured maximum variation sampling by including students from high, average and low performance categories. Participation was voluntary. Interviews were conducted using a short interview guide, transcribed and themes identified.

Results: 21 interviews were conducted. There were eight, six and seven volunteers from the high performing, average and poorly performing groups respectively. 63% were male.

Positive experiences encompassed; trainer taking a balanced approach to feedback by acknowledging good practices while indicating negative aspects, providing an emotionally supportive environment, clear articulation, offering focused learner support and motivating the learners through encouraging words and support to realize their potential. Negative experiences encompassed fault finding, biased nature and indiscreet behaviour of the trainers.

Conclusion: Sri Lankan medical graduands have experienced desirable and undesirable teacher behaviours during feedback episodes. Accurate conceptualization of 'feedback process' among clinical teachers and proactive measures to enhance the skills of teachers on giving feedback is needed.

Keywords: *Undergraduate Clinical Training, Student Perceptions, Feedback*

Practice Highlights

- Students call for a balanced approach in providing feedback.
- Sense of respect for the learner is solicited.
- Offering learner support is highly valued.
- Negative comments better be non-judgmental and descriptive.
- Accurate conceptualization of feedback process among trainers is a dire need.

I. INTRODUCTION

Feedback to a learner is an important aspect of teaching and learning and is essential in the acquisition of skills as well as development of competencies. In this era of outcome-based education, teacher feedback to learners plays a crucial role in the development of competence in medical training (Ende, 1983; Harden & Laidlaw, 2017). It becomes especially important in medical education in a hospital environment where teaching/learning occurs in an opportunistic manner in the presence of numerous other onlookers.

It is reiterated that in clinical practice, feedback reinforces good practice, identify deficiencies and directs

the learner to narrow the gap between actual and desired performance (Bing-You, Paterson, & Levine, 1997; Bing-You & Trowbridge, 2009; Cantillon & Sargeant, 2008). Furthermore, Ponnamperuma (2015) argues desired performance should not be static but dynamic depending on the progress of the learner, emphasising the role of properly directed feedback in assisting enthusiastic learners to realise their potential. Similarly, Hesketh and Laidlaw (2002) argued feedback is essential element of the educational process that can help students reach their maximum potential. However, one should be mindful that feedback if not carefully handled can result in de-motivation and deterioration in performance (Cantillon & Sargeant, 2008).

Much highlighted educational alliance approach is based on a mutual understanding of purpose and of responsibility for learning. This alliance is complex with equal responsibility by the learner to learn and the teacher to teach (van de Ridder, Peters, Stokking, de Ru, & ten Cate, 2015). Barriers to effective feedback include, the purpose of feedback being unclear to the teacher (provider), and learner (recipient), unavailability of appropriate place or inadequate time to complete feedback and minimal or no training provided to the trainer in providing feedback (Hesketh & Laidlaw, 2002; Ponnamperuma, 2015).

van de Ridderet al. (2015) indicates that the effect of feedback may be small, if not given appropriately. However, it is well-known that for feedback to be of maximum benefit, learners' too need to use and engage with the feedback processes appropriately. This concept which is known as “proactive recipience” includes, characteristics and behaviours of the receiver, sender; the message and context (Interpersonal communication variables); as well as recipient’s processes such as self-appraisal, assessment literacy, goal-setting, self-regulation, engagement and motivation (Winstone, Nash, Parker, & Rowntree, 2017).

A study conducted by Bose and Gijselaers (2013) supported the assumption that supervisors who promote residents to seek feedback with motives of self-improvement should also ensure that their students’ concerns of ego-protection and impression-defence are addressed during the process. van de Ridder et al. (2015) further states that the manner in which the message is framed, whether it is positive or negative affects students' satisfaction and self-efficacy directly after the intervention even though it is known to fade-out over time.

Further it is believed that national culture plays an important role in the way behaviours are valued and tolerated in educational settings; Hofstede (2001), reported relatively higher power distance indices for South Asia. Sri Lanka being a South Asian country, the hierarchical nature of organisational arrangement is observed. Thus with the existence of high level of power distance between undergraduate students and academic staff, it is not customary for the students to argue with teachers or challenge teachers, even if the teachers deviate from accepted practices. In Asian cultures, the child-parent role pair is replaced by the teacher-student role pair (Hofstede, 2001) leading to observed paternalistic culture in Universities. Hence feedback tends be more of fault-finding with use of punitive measures as a means to change behaviour and it is likely that the trainees accept some of the negative behaviours of teachers (which are unlikely to be accepted by those in the West), considering it to have been done in good faith.

Bowen, Marshall and Murdoch-Eaton (2017) have identified three learner feedback behaviours; recognising, using, and seeking feedback. He proposes that core themes such as learner beliefs, attitudes, and perceptions; relationships; teacher attributes; mode of feedback; and learning culture influence these behaviours. Further, Perera, Lee, Win, Perera and Wijesuriya (2008) have reported perceived mismatch between the expectations of the provider and the receiver in an Asian context.

A survey on students’ perceptions of teacher feedback conducted in the Sri Lankan faculty by Mudiyanse, Pallegama and Marambe (2015) highlighted the existence of several deficiencies. Paucity of recent literature on perceptions of Sri Lankan undergraduate medical students on the feedback practices, prompted us to explore the issue of teacher feedback and its effect on students. As educationists, we believe an exploration of the actual situation would help understand the factors, which facilitate learning among Sri Lankan trainees, thus paving the way for informed decision-making. Hence the objective of the proposed study was to explore perceptions of Sri Lankan medical graduands to feedback received from teachers during clinical training.

II. METHODS

A qualitative inquiry informed by semi-structured interview was performed. The study sample was selected based on the final year results of a single intake of students in one medical Faculty within 3 months of release of results (this group of passed-out medical students awaiting award of degrees at the convocation is defined as graduands). Maximum variation within the sample was ensured through stratified random sampling technique. Fifteen students (8 males) were selected

randomly by the research team from each achievement group namely, high achievers (those who secured classes–Group A), average students (those who secured ordinary passes–Group B) and poor performers (those who referred in any one final year subject–Group C).

Prospective participants were provided relevant information about the study via email and invited to be present for a short interview. They were informed that the interviews will be tape-recorded and transcribed for better comprehension and that confidentiality would be ensured. Those willing to participate in the study were instructed to contact the principal investigator by email. The volunteers were given appointments for the interview.

The nature of the study was explained to the volunteer and consent was obtained for audio recording by the Research Assistant (RA) prior to the scheduled interview. All interviews were conducted by the same interviewer in a sound-proof room, in the faculty-based on an interview schedule, which consisted of two open-ended questions. The probes used to obtain genuine responses were to recall a situation based on personal experience, during clinical training, where they were given, 1) constructive feedback and its impact on learning and 2) de-motivating feedback; and its impact on learning. Measures were taken to ensure anonymity.

Subsequently, the interviews were transcribed and read independently by three researchers with experience in qualitative research. Quotes were selected by the three researchers independently and grouped to identify broad themes. The broad themes identified were compared and consensus was achieved on common recurring themes, representative of the perceptions of undergraduate medical trainees on positive and negative experiences in receiving feedback.

III. RESULTS

Eight volunteers from the high achiever group (A), six from average group (B) and seven from referred group (C) amounting to a total of 21 students (63% males) were interviewed. Majority of the experiences with feedback (teacher to trainee) during clinical training in the third to fifth undergraduate year were rated as good. It was revealed feedback has been practiced more often, informally and systematically in the final year. According to interviewees, the majority of clinical teachers had listened to case histories presented by undergraduates and given feedback on the relevant and useful points for diagnosis and planning of management to the student concerned and others in the group during regular ward teaching sessions. Some of the assigned trainers have observed the physical examination techniques of students, clinical procedures and provided feedback to the student concerned, while others in the group also benefited from it.

Analysis of trainee perceptions of positive and negative feedback episodes during undergraduate medical training resulted in the identification of the four themes given below as those which motivated and enhance learning. Selected excerpts representative of all achievement groups, are included as evidence under each theme.

The positive experiences are centred on four themes presented below.

A. Balanced Approach to Feedback

Most of the interviewees valued when the feedback provider set the scene by acknowledging or appreciating the good aspects demonstrated by the trainee, while focusing on deficiencies whether it be history taking or examination.

"The teacher praised us for the good things we did in ward teaching sessions. Good practices were acknowledged during ward rounds ... mistakes pointed out. Since the consultant capitalised on good things I did, I did not feel 'belittled'."

(A16)

"Teachers observed us, gave immediate feedback. First appreciated the thing done correctly, then advice was given to correct mistakes"

(B16)

"When good practices are highlighted we feel good. What we have missed were also pointed out ... confidence increased"

(C7)

B. Demonstrating Respect for Learner

Respect for trainee and engaging in a dialogue, providing a non-threatening learning environment was mentioned as a factor which enhanced learning. These approaches include unbiased and unprejudiced behaviour, less hierarchical context, focus on specific performance and feedback phrased in descriptive, non-evaluative language. The other approaches include, use of neutral language, non-threatening tone of voice during feedback episodes, being sensitive to learners' emotional status, taking measures to maintain privacy. The trainers' behaviours underlying the episodes perceived as positive experiences by many interviewees consisted of features

described above. Trainees sensed a lot of educational value in the caring, approachable, unbiased, respectful conduct of the trainers.

"The one-to-one feedback in clinical training is a good feature. We felt we could ask questions from the consultant and get some of the doubts clarified."

(A15)

"We were treated like doctors. We could ask questions without fear, no big distance between student and teachers."

(A5)

"So, I was encouraged to clarify my doubts in this manner. Never shout at us, so we were free to ask questions and behave in the ward. Adorable teacher, we could ask questions without fear."

(A13)

"In a clinic setting, I was not thinking of privacy. Teacher called me to a room, ... blamed for what was done. Got me to think if she was my mother ... So, taught me about consent, privacy."

(B15)

"The nature of the consultant, non-judgmental when I made mistakes, but tried to correct me by making a point clear. Not exceeding limits."

(C11)

C. Clear Articulation and Offering Learner Support

Interviewees valued instances where the trainer provided focused advice, explained the mistakes made by trainees and offered adequate direction for improvement to the trainee. Providing clear descriptions of observed behaviour was felt to be more palatable and useful from the point of correcting one's mistakes.

"I was okay with facts, I was observed during the process by a senior registrar and …, told me that I take more time–I was too slow. I was instructed to examine more abdomens of patients while in the ward, I did it and it became very useful."

(A4)

"I was advised on how to organise histories, how to rearrange my history to suit final year requirements."

(A8)

"We were supported, shown how to examine the patient correctly when we made mistakes. Directed us to read around …. Also, checked whether we have improved later"

(B1)

"What we have missed were also pointed out ... We were shown correct techniques."

(C7)

"end appointment viva, OSCE were held, one–to-one feedback. Wrong things we did were pointed out in a nice way. Focused, so we knew how to go about to improve knowledge."

(C4)

D. Boosting Moral and Self- Esteem of Trainees

The interactions with trainees had been such that the trainer having identified the potential of students made them aware of it and motivated trainees to realise their full potential.

"I was identified as a good student by the clinician …, I was made aware of my potential, this I found encouraging and I tried to work better from then on in fact, it resulted me getting classes in later years."

(A6)

"I was asked a simple question about ECG, when I did it right, I was praised… 'you will become a consultant', and later I came across an unusual heart sound and I told the consultant about it, he examined and also got the Registrars to listen to that so, I was encouraged to clarify my doubts."

(A13)

"Third year teachers motivated me. They supervised us and corrected. All of us got a chance to do hands-on skills training….supported learning"

(C3)

The negative experiences are centred on four themes presented below.

A. Fault-Finding and Judgmental Nature

Some of the expressions on negative experiences highlighted instances where feedback lacked acknowledgement of what was done right and encouragement, and being more of fault-finding exercise.

"When there are gaps in knowledge, the way teachers reacted at the start was not encouraging. We worked really hard, spent 3 whole nights in the ward. We get

punished because 2-3 students in the group made mistakes. We are not rewarded for work we do."

(B1)

"One clinician wanted to discuss a particular problem. … My patient had this problem found through a scan. …Unfortunately when the teacher examined, positive signs present because of full bladder. I was told that I will definitely repeat. I cried. I avoided the teacher. Still it haunts in me. Comments such as 'you do not have a passing face' was made, I was worried. Sad, when first impressions get carried through the appointment."

(B15)

"I volunteered to present a case, I could not make a correct diagnosis and I was told I have cheated."

(C11)

B. Biased Nature

Above refers to teacher referring to previous performance of a student in giving feedback to a new situation. Students feel if a mistake is made once that student gets noted and will be targeted and treated differently for the same mistake.

"Some students are treated differently. Even if we give correct answers, told not up to the mark."

(B16)

"Some students were selected and they got scolded in front of everybody, I felt some of them worked very hard, when they make even a slight mistake, without giving credit to what was done right they got scolded."

(A16)

"I felt expressions made following observations of performance were highly biased. Sometimes tend to generalise and make comments about students which are not true."

(C3)

C. Indiscreet Behaviour of Trainers

Trainees perceived some environments as hostile, disrespectful, revealing things that should be private as illustrated by following phrases that were used to describe negative experiences.

"Embarrassing when … shouts at us, I think people have reasons for making mistakes. During ward rounds, scolding in front of patients in Sinhala, discourage students. Thereafter, students avoid these patients and lose chances of learning. I felt we were treated as school children."

(B16)

"Certain appointments too scared of the consultant did not expect good feedback. Very harsh comments."

(A18)

"Told you will fail, I did not see a fair reason to do so. Specially at a time when one is about to complete training before final exam. Last opportunity to learn in the course is lost. All your expectations are lost. There are better methods to motivate. What was done was unpleasant. Comments made are: you are bad- cannot do, I do not think you can pass."

(B17)

D. Punishments in Addition to Feedback

Graduates also mentioned about instances where punishments were made in addition to negative feedback.

"Comparing students and scolding these students in front of others made them depressed. I have heard of students being punished when a wrong answer is given."

(B14)

"Maybe one wrong answer, repeat for one month."

(C5)

"Sometimes members of a group have to undergo punishment due to the fault of others in the group, like not presenting histories, being absent."

(C14)

IV. DISCUSSION

It can be concluded that in most feedback episodes, interviewees have benefitted from trainer feedback, which has been balanced and supportive. Acceptance of more frequent, informal, timely, balanced and focused feedback was obvious in the expressions of trainees of all groups. However, the existence of variations among clinicians in the style of giving feedback was also evident. The Sri Lankan graduands valued acknowledgement, appreciation, praise of demonstrated good practices or desirable behaviours, by trainers during feedback sessions. In the Sri Lankan culture praise or words such as 'excellent', 'very good' and 'good' are used by teachers to acknowledge achievement of expected standard by students. Thus, interviewees endorsed the potential of simple measures in reinforcing good behaviour reported by Thorndike (1931) and Krackov (2009). Interestingly, Sri Lankan graduands, a group of South Asians, highlighted most of the characteristics of effective feedback found in literature under positive experiences, though hardly mentioned practices such as providing feedback as desired by the

recipient and checking for understanding of the plan of action/ remedial measures (Matua, Seshan, Akintola, & Thanka, 2014; Ramani & Krackov, 2012; Rose, Best, & Higgs, 2005). Also, emphasis on reinforcing desirable behaviour during feedback episodes was not prominent in the expressions. In this regard, Ponnamperuma (2015) was of the view that 'reinforcing desirable behaviour is rather conservative in South East Asian region' compared to the West.

Similar to the findings of Hewson and Little (1998), most of the Sri Lankan interviewees endorsed feedback episodes where clinicians created a respectful environment were effective in enhancing learning and self-esteem. In such environments interviewees reported they are not in fear and hence tend to ask questions for clarification, and request support from different levels of clinical teachers, work with an inquiring mind and thereby enhance their knowledge and skills.

The trainees have perceived many advantages of balanced feedback that is trainer initiating the feedback dialogue by acknowledging and praising (which is more than acknowledgement) the observed good practices, later commenting on observed gaps in competencies, discussing remedial measures and finally incorporating monitoring strategies to ensure the attainment of competencies. Boud and Molloy (2013), have argued these as desirable aspects, which enhance learner engagement in a feedback model. Sri Lankans also endorsed the effect of such feedback on boosting confidence (Bing-You et al., 1997; Cantillon & Sargeant, 2008; Krackov, 2009, 2011). Ready acceptance of such balanced or even- handed feedback reported by Hewson and Little (1998) and Ramani and Krackov (2012) was apparent among Sri Lankan trainees.

Ponnamperuma (2015) indicated one of the expected roles of feedback is to challenge learners to realize their potential which demands extending the desirable level of competency for learners progressing well. It was encouraging to note that some of the interview excerpts referred to fulfilment of this role by the local trainers.

However, analysis of narratives on negative feedback episodes revealed desirable practices are not entirely prevalent in the Sri Lankan context. In describing features of negative feedback episodes, words such as 'hostile' and 'tensed' were frequently mentioned and majority doubted its effect on motivation and promoting learning. According to interviewees this situation has led to the emergence of 'feedback phobia', resulting in the avoidance of such teachers. Reflecting on the negative experiences of many interviewees, it is clear that the trainees request feedback to be made on direct observations of trainee performance in all encounters, using neutral language and a respectful tone which are the prescribed good practices in literature (Ramani & Krackov, 2012; van de Ridder et al., 2015). As reiterated in literature, it is important for trainers to maintain privacy and confidentiality particularly, when providing negative feedback (Ponnamperuma, 2015).

Further, being conscious of the tone and language used in feedback encounters is an absolute necessity to avoid de-motivation (Hewson & Little, 1998; van de Ridder et al., 2015). In this regard Ponnamperuma (2015) states negative feedback, if handled in a wrong way, can damage self -esteem, create a 'feedback phobia' leading to avoidance of such trainers and training opportunities.

Evidence suggests feedback phobia is not uncommon in the Sri Lankan context. Hence it is essential to frequently remind the trainers to be objective, unbiased and unprejudiced during informal feedback encounters and thereby ensure a favourable emotional climate, being sensitive to recipient's emotions. A creative trainer would thus initiate a dialogue with the trainee, provide a space for the recipient/trainee to clarify the feedback and later offer guidance and support to enable accomplishment of competencies (Harden & Laidlaw, 2017). However, it is known that creativity requires time and effort on the part of a busy clinical trainer. In order to change the situation for the better, it is recommended regular faculty development programs include theory and practice of constructive feedback models (Boud & Molloy, 2013).

Quoting some of the observed undesirable practices in the South East Asian region, Ponnamperuma (2015) expressed doubt on accurate conceptualisation of feedback by both the provider and the recipient. Analysis of the negative experiences described by the graduands, raises concerns on the level of conceptualisation of feedback among some of the trainers in the Sri Lankan context. For example, interviewees revealed, though identifying undesirable behaviour was commonly practiced by the trainers, in most instances, they were not backed up with options and support for improvement. Hierarchical and paternalistic culture seems prominent in the Sri Lankan context leading to arrogant behaviours of some teachers during feedback episodes (Hofstede, 2001). Furthermore, as exemplified by interviewee quotes, the reaction of some of the clinical trainers had not been proportionate to the mistake made by the trainee concerned and trainees had been left with a sense of helplessness leading to negative repercussions such as emotional distress. Imposing punishments like non-signing off of clinical appointments, in addition to providing negative feedback has resulted in developing

feedback phobia and avoidance of training opportunities (Ponnamperuma, 2015).

The graduands have experienced at least a few feedback encounters which were not effective, de-motivating and stressful; this need to be addressed constructively. Ende (1983) was optimistic that after some practice and planning, provision of feedback in clinical medicine is not as difficult as one might think. In this background, there is a need for the administrators to initiate a dialogue on institutional-level student feedback policy. Developing a contextualised feedback framework through active engagement of clinical teachers encompassing Pendleton's rules (Pendleton, Schofield, Tate, & Havelock, 2003) or Agenda-Led Outcome Based Assessment (Chowdhury & Kalu, 2004), which are learner mediated, will be a step in the right direction.

Recently, Findyartini, Bilszta, Lysk and Soemantri (2019) had reported the effectiveness of employing strategies ensuring active engagement of participants during Faculty development initiatives, leading to cross-cultural adaptation of best practices in clinical teaching. Hence organising workshops for clinical teachers where they are made to reflect on student narratives of positive and negative feedback episodes in the light of good practices could be a useful strategy to promote adoption of desirable behaviours.

V. CONCLUSION

Positive and negative feedback experiences were revealed by Sri Lankan graduands. Features of effective and ineffective feedback episodes in the minds of Sri Lankan trainees are mostly the same as those reported in literature based on Western studies. However, graduands have perceived the existence of conservative behaviours among some of the teachers such as being more interested in fault-finding with less emphasis on discussing corrective measures. Hence it is speculated some of the trainers could be having a 'culturally coloured' concept of 'feedback', which needs urgent attention in order to realise the educational benefits of feedback. Since Feedback is a powerful learning tool in medical education, all efforts should be made to enhance the skills of trainers on giving feedback to learners.

Notes on Contributors

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Ethical Approval

Ethics approval for the study proposal was obtained from the institutional ethics review committee of the University, Sri Lanka (Ethics approval number 2017/EC/69).

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Declaration of Interest

The authors have no conflict of interest.

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