Resident Teachers and Feedback: Time to Raise the Bar

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Medical student learning is powerfully influenced by the residents with whom students interact. Recognizing the importance of residents as teachers of their students, medical schools are increasingly asking—and being asked by accrediting bodies—how residents are prepared for their teaching role. Supporting residents to be effective teachers requires not only a sound notion of what attributes influential teachers possess, but also a plan for how those traits can be nurtured. Two papers in this issue address these issues. Melvin et al[1] address the first requirement by exploring medical students' perspectives on the qualities they most value in resident teachers. Tuck et al[2] address an aspect of the second requirement, exploring residents' perspectives on the feedback they receive from students—feedback intended to develop and enhance their teaching performance. The articles offer useful insights into how we can define and support effective teaching among residents. Both articles also highlight the larger, thorny problem of feedback in medical education.

Feedback is widely endorsed as an essential facilitator of learning. Thirty years ago, Ende[3] warned that without feedback, "mistakes go uncorrected, good performance is not reinforced, and clinical competence is achieved empirically, or not at all." But the achievement of competence cannot possibly hinge on feedback unless the feedback offered is of good quality and the process by which it is received and acted upon is understood and supported. Despite a great deal of emphasis on the importance of feedback for learning, and monumental efforts to train faculty—and residents and students, for that matter—in how to deliver feedback, medicine remains plagued by vague and often meaningless feedback. Research on feedback conducted during the last few decades has helped us to understand why.

Historically, much of the work on feedback has treated it as a commodity, focusing on how to construct and deliver it, with little attention given to what happens next. Issues of construction and delivery are not unimportant; few would dispute the idea that feedback should be specific, timely, based on observable behavior, credible, and actionable in order to be perceived as effective. How feedback is given, however, is only part of the picture. How feedback is received, reacted to emotionally, judged, and integrated by learners is equally critical.[4] Feedback that threatens self-esteem, or that is in conflict with self-perception is very difficult for learners to use, regardless of how carefully it is constructed and delivered.[5] Learning culture—the environments, opportunities, pedagogic approaches, and professional values that underpin the educational experience—is an added important influence, supporting or sometimes constraining the exchange of meaningful feedback.[6]

Medical education struggles in each of these areas. Despite persistent attention to the construction of high-quality feedback, learners continue to be underwhelmed by the quantity and quality of feedback they receive, as the findings by Tuck et al[2] show. Even when feedback is received, much of it is perceived as vague, nonspecific, and lacking in a clear plan for performance improvement. When feedback is challenging or critical, there is a real risk that it will be dismissed or discarded by learners, particularly if it conflicts with their self-assessment.[7]

In addition, medicine's learning culture has not been especially supportive of the exchange of meaningful feedback. Many clinical learning environments limit opportunities for the routine, direct observation of learners in action. Learners are often scheduled to rotate with multiple supervisors for short periods of time, which inhibits the development of trusting, longitudinal teacher-learner relationships. Teachers are typically required to take on coaching and assessment roles simultaneously for their learners, even when the goals of these roles may conflict. Formal feedback mechanisms often require teachers to comment on a full range of competencies, even when they have only observed a limited range of performance from their learners. Inevitably, these pedagogic decisions diminish the quality and credibility of the feedback that can be exchanged.

Is it any wonder, then, that the students in the study by Melvin et al[1] ranked giving feedback relatively low among resident teacher traits they valued, and did not perceive receiving feedback as particularly useful for their learning? Too often, the feedback offered up in medicine is ill-informed, nonspecific, and lacking in direction and

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credibility. For learners, this practice begins to define the notion of feedback for them as something of limited value. The article by Tuck et al[2] paints a slightly more encouraging picture of the value learners place on feedback. However, their finding that most residents, despite opportunities, were not receiving formal feedback from students on their teaching abilities reinforces the reality that feedback often is disappointing.

For learning to occur in clinical settings, the environment must provide opportunities that can enable learning, *and* the learners must choose to engage with those opportunities.[8] Learners gravitate to the opportunities that they perceive as most valuable; their decisions are shaped both by what they see as most productive for their learning and what they see as valued by the profession.[9] The routine provision of empty feedback may lead to the process of exchanging feedback being devalued by learners. Melvin et al[1] suggest that students might not have rated resident-delivered feedback as important because they may have misunderstood the meaning of "feedback." I would offer the disconcerting alternative explanation that their experience has already taught them that the feedback typically provided is of limited value to their learning. Tuck et al's finding that most residents were not formally reviewing feedback on their teaching during regularly scheduled meetings with their advisors, despite a requirement that such a discussion should occur, further paints a discouraging picture of the value that the culture places on these feedback conversations.[2] By highlighting the disconnect between "what educators and residents would like to have happen and what is happening," Tuck et al[2] demonstrate that the success of feedback rests on more than the goodwill of individuals and their faith in the notion of feedback. The learning culture also must value feedback, make good feedback available, and prioritize the conversations that facilitate the uptake and use of that feedback.

The problem is not that feedback cannot serve as an effective facilitator of learning, but rather that the particular type of feedback we have come to accept often falls well short of the mark.

Residents as teachers may be particularly well positioned to challenge this uninspiring status quo. Their physical proximity to students in the clinical setting gives them ample opportunity to observe how these students perform, and their emotional proximity to the students' experience may enhance the all-important relational aspect of feedback. Residents have the time with students needed to develop trust and to allow challenging feedback to resonate, and they are less likely to shoulder the responsibility for high-stakes assessments. Residents are thus more comfortably positioned in a coaching role. It is time we create a new culture where honest formative feedback is frequent, routine, and valued. Residents as teachers provide a real way forward.

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