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Bedside Teaching in the Emergency Department: A Model for Delivering Effective Learner-Centered Feedback

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Abstract

Providing learner-centered feedback that is direct, well-timed and based on objective data is one of the most effective tools we have in medical education. The absence of feedback is a missed learning opportunity: good performances are not reinforced and poor performances remain uncorrected. Some common models for delivering fail to address the significance of why feedback is being given and may dilute the intended message. The overarching objective of this work is to underscore the importance of learner-centered feedback, discuss the limitations of providing feedback in the emergency department (ED) and to provide a model of what we learned based on seminars, survey data and feedback from conference presentations that works well in giving feedback. The model has been introduced locally and pilot data for its effectiveness are presented herein.

Keywords

Feedback, Learner-Centered, Bedside Teaching, Crucial Conversations, Knowledge Gaps

1. Introduction

Providing learner-centered feedback that is direct, well-timed and based on objective data is one of the most effective tools we have in medical education (Hattie & Jaeger, 1998). The absence of feedback is tantamount to missed learning opportunities: good performances are not reinforced, and poor performances remain uncorrected. Moreover, learners may have to learn by trial and error at patients' expense (Van De Ridder et al., 2008), which is a detrimental situation for both the patient and the learner, i.e., the default mindset in the absence of

feedback is that learners think they are doing the right thing regardless of any standards or benchmarks. Poor outcomes stem from poor decisions and misaligned knowledge or experiences—the underpinnings of why an action resulted in a suboptimal outcome (Rudolph et al., 2006; Cantillon & Sargeant, 2008; Rudolph et al., 2008).

While we note feedback is an effective teaching tool, providing feedback in hectic environments like of the emergency department (ED) can be difficult given the significant time constraints in the ED, the emergent needs of the patients and unexpected critical situations and crises inherent to the clinical responsibilities of the ED. Nevertheless, the balance of teaching and providing patient care can be met in the ED to both ensure our learners are being well trained and our patients are receiving excellent care. We describe a simple model as an aid in providing more effective learner-centered feedback.

The overarching objective herein is to underscore the importance of learner-centered feedback, discuss the limitations of providing feedback in the emergency department (ED) and to provide a model of what we have learned works well in giving feedback. The model has been introduced locally and pilot data for its effectiveness are presented herein.

2. Methods

We conducted professional development seminars which presented a model for providing improved, real-time formative feedback to learners (e.g., residents and medical students). The seminars addressed the emotional aspects of giving feedback and why in the right circumstances negative feedback can be well-received and how best to provide feedback in the often-chaotic environment of the ED. We initiated this intervention because many educators noted their lack of experience in providing substantive formative feedback especially their confidence in giving negative feedback. Approximately 310 attendees (faculty, fellows, residents, nurses) participated in the seminars. Specific outcomes regarding feedback ascertained from emergency medicine faculty via survey (N = 15) are provided herein.

3. Results

As part of our pilot study, we queried faculty participants about two key aspects of the sessions. Using a Likert scale (1 = strongly disagree - 5 = strongly agree) as follows. 1) The session regarding feedback was helpful to me and 2) My ability to provide feedback has improved since the session. Preliminary data (N = 15) demonstrate scores for queries 1 and 2 to be 4.63 ± 0.49 and 4.53 ± 0.74, respectively. A didactic session regarding feedback was also given at three national emergency medicine conferences where the session received positive participant evaluations (96% positive, N = 24). Moreover, comments noted the model was easy to use and often led to meaningful conversations between the teacher and the learner. A major key for faculty was acknowledging that providing feedback is an emotionally charged process regardless of experience, situation, and level of

training of participants. However, in an attempt to avoid negativity, we miss opportunities to teach and correct gaps in learners' knowledge.

4. Discussion

Some common models for delivering feedback (e.g., the feedback sandwich) fail to address the significance of why feedback is being given and may dilute the intended message (Cantillo & Sargeant, 2008). Directly addressing a negative outcome with specific observations will more efficiently address performance gaps but this may involve emotional barriers (Cannon & Witherspoon, 2005). To readily address this requires recognition of feedback which often falls into two categories: prevention mode or promotion mode. Prevention mode entails obligations, duties and tasks which requires vigilance to do and a sense of relief when the task is completed (e.g., maintaining credentialing and licensure). Promotion mode entails creative endeavors which require eagerness and a goal of personal reward and praise, for example producing a creative or artistic work. Negative feedback in preventive mode is often well received, e.g., telling a learner who is late for their shift to show up on time next shift. Criticism of a creative endeavor could be hurtful, for example being told your new cooking recipe could taste better. For the most part, clinical medicine is rooted in prevention mode; we seek to avoid mistakes, and we are vigilant and ever mindful of negative outcomes (Klueger & Van Dijk, 2010). In these situations, negative feedback works best, thus why it is both necessary and permissible to give negative feedback. Negative feedback (feedback aimed at closing a learning gap) is best done using objective information (what was observed or heard) followed by subjective thoughts or ideas (what you feel and think) (Abraham & Singaram, 2019). Avoiding emotions is nearly impossible since the learner may feel they did something wrong rather than see an opportunity to improve. An analogy may be like eating a burrito but only trying to bite the inside. The tortilla is the emotions holding all the valuable content of the feedback. Each bite includes both the tortilla wrap and the content filling. By understanding the connection of feedback on emotion, the educator will be better prepared to provide feedback even in difficult, emotionally charged situations. Simply stating "can I give you some feedback" or some similar comment can attenuate emotions for both educator and learned. Another aspect to consider is feedback must be a conversation between teacher and learned and this flow in a natural unforced manner. Such conversations occur constitutively in the ED and thus opportunities for learner-focused feedback exist in nearly every patient encounter and interpersonal interaction.

There are several important limitations to giving feedback in the ED (e.g., patient volume, time constraints and interruptions) and these constraints are further limiting when coupled with the duality of providing both quality patient care and meaningful education experiences. Thus, the timing of feedback is important. In a critical situation, feedback too soon will not work because learners will not be prepared emotionally. However, simply stating you are about to have

a discussion regarding an event may help overcome this barrier and prepare the learner for feedback (Carlos et al., 2016). Further, feedback can be delayed until after the shift if the learner understands you want to have a conversation about their shift performance.

5. Conclusion

Some crucial keys to giving feedback include recognizing whether you are dealing with a preventive versus promotion situation, preparing the learner that they are about to receive feedback, providing objective example when giving feedback and timing the feedback to maximize improvement. Recognizing emotions is also very important to both giving and receiving feedback. For example, our pilot program based on emphasizing these concepts was successful based on evaluations we received. Further work will focus on expanding the methodology to other specialties such as critical care, anesthesia, and rapid response teams.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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