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Feedback works at its best when it inspires reflection on behaviour and performance. Uncritical praise or criticism alone is rarely effective.

Why is feedback so difficult?

Feedback is decisive to achieve good learning, but giving appropriate and constructive feedback to learners can be a difficult matter. Most teachers will have experienced incidents when feedback was provided in an unfortunate manner and thus did more harm than good. This may cause the teacher to become more cautious in providing feedback out of fear of being perceived as too critical and negative. A golden opportunity for improvement is thus being squandered: the student remains unaware of what is good and less good, and incorrect notions and poor practices is not corrected.

Feedback can reinforce, modify and improve practice, but may also erode motivation and cause performance to deteriorate (1). Whether a feedback message will have a positive or negative effect depends on the way in which it is communicated and how it is received. As teachers, medical doctors have little training in providing feedback in an adequate manner: some hardly provide any feedback at all, or only point out mistakes. Students and junior doctors all want feedback from their supervisors and superiors, but are often disappointed by the amount (too little) and the way in which it is provided (2). Some students – fortunately only very few – appear to be unreceptive to feedback, even when it is adequate, well-intended and constructive.

There are certain general principles for providing good and effective feedback in learning situations (3). The most important one is perhaps making clear from the start that giving and expecting feedback is self-evident – in both directions. A culture for providing praise, advice, criticism and conversation needs to be established. The criteria for good performance should be defined in advance. The best feedback is feedback that inspires reflection on performance and how the performance can be improved. Pointing out specific aspects that can be improved is better than providing general appraisals. Feedback should be linked to observed performance, preferably immediately after or within a short period of time, and should be restricted to only a few items in each round. Many take care to first state what they see as positive before pointing out what needs to be improved. This may work well, but may also cause the learners to close their ears and just wait for what will come after the word «but».

Practices for providing feedback in medical schools have not been widely studied. It has been claimed that feedback in medical training is too teacher-centred, too focused on positive or neutral aspects, and that the students are insufficiently encouraged to reflect on their own performance (1). Other reports tell of more criticism and censure than praise and advice (2). The explanation may be simple: it is more pleasant to provide and receive praise than criticism, and it is easier to point out mistakes than to inspire people to think. But the learning outcome will be poor.

Studies indicate that medical doctors as a group have a limited ability to assess their own performance and skills adequately and often overestimate their own abilities (4). This applies especially to those whose performance is objectively poorest and to those with most self-confidence. Accordingly, it is not uncommon for doctors to react to criticism with disbelief, or for students to be surprised when they receive feedback that is incongruent with their own view. Criticism threatens their self-image. This may elicit emotional reactions that could hinder insight and adequate learning.

Is today's generation of students characterised by an upbringing that places a strong emphasis on how children are unique, special and gifted – no matter what they do? Does this make them less receptive to critical feedback as students? Has too much emphasis been given to the role of the teacher in the feedback dialogue at the expense of the role of the student? Some years ago, two university teachers of medicine posed these questions in the American journal *JAMA* (1). They pointed out three reasons why many medical teachers fail in giving feedback: poor ability for self-assessment, an exaggerated tendency to react emotionally to criticism, and insufficient meta-cognitive skills, i.e. deficient ability to self-reflect on reactions and thoughts, among some students.

Medical students and junior doctors would like to have more and better feedback on their own performance than what they receive today. This deficiency may have several causes, including limited resources, high requirements to service production and lack of time. I believe, however, that more often the reasons are bad habits, misconceived caution and insufficient training in giving and receiving feedback in an appropriate and effective manner. Have we become too afraid of speaking our mind?

Medical teachers and supervisors need to improve their feedback skills. This can only be achieved through raising awareness, more training and practice and – yes – feedback on their feedback practice. Both teachers and learners need to be prepared for both negative and positive feedback and to regard both as necessary to become better doctors.

References

1. Bing-You RG, Trowbridge RL. Why medical educators may be failing at feedback. JAMA 2009; 302: 1330–1.
2. Losvik OK. Der den høyeste form for ros er fravær av kritikk. Tidsskr Nor Legeforen 2013; 133: 1690.
3. Cantillon P, Sargeant J. Giving feedback in clinical settings. BMJ 2008; 337: a1961.
4. Davis DA, Mazmanian PE, Fordis M et al. Accuracy of physician self-assessment compared with observed measures of competence: a systematic review. JAMA 2006; 296: 1094–102.