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LETTER

Advocating a bottom-up approach in the teaching of feedback skills to medical students [Letter]

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Dear editor

Jamshidian et al[1] discuss medical teachers' opinions regarding sources, methods, content, and presentation of feedback. We agree that feedback provision in medical education is beneficial for personal and professional growth, but that it can be relatively poor in quality, particularly regarding "authenticity of data sources," "data gathering methods," and "choosing an appropriate feedback presenter."[1]

We suggest that the lack of adequate feedback provision stems from medical school, where feedback is passively incorporated into students' learning via surveys and questionnaires, and techniques of providing feedback are often not explicitly addressed.[2] To strengthen quality and authenticity of student feedback, these techniques should form a core component of medical education curricula. Jamshidian et al[1] propose a feedback cycle offering a top-down approach to improving feedback provision, where recipients use feedback to adjust their behaviors. We suggest this should be used in conjunction with a bottom-up approach, where effective feedback provision techniques are formally taught early in education.

Additionally, feedback can be influenced by the status of the feedback provider.[1] The authors mention that the most important criterion for the feedback provider was their "acceptance" by the recipient. The researchers' interviews revealed that a "competent clinical teacher," ie, a medical education expert, was the preferred feedback provider. However, this is incongruous with another result of their study, which identified students as the best source of feedback. We propose that formally teaching students how to deliver and provide feedback may help change the way in which student feedback is being perceived, by giving students the same authority as medical education experts. Instead of using a model that focuses on interactions between providers and recipients, students should be taught simple, structured frameworks on giving feedback.[3]

Furthermore, the application of emotional intelligence, ie, techniques and insights that help humans perceive their own and others' emotions, in teaching has led to improvement in clinical teachers' performances.[4] Application of emotional intelligence could also avoid "negative emotional reactions such as denial and defense," experienced by some of the teachers in Jamshidian et al's study,[1] and allow clinical teachers to reflect on feedback content objectively.

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The delivery of additional feedback using qualitative analysis has also improved the level of acceptance of feedback in medical students.[5] Such tailoring and personalization of feedback to the recipients' traits may reduce the likelihood of emotional volatility, create a positive environment, and strengthen the quality of feedback and mutual respect and understanding between provider and recipient, to increase learning and improve patient care.

In conclusion, we believe students should become medical education experts through rigorous feedback training, which should emphasize a personalized approach for a positive reception. As doctors begin receiving feedback in medical school, it is the university's duty to assume responsibility for such training. Given the paucity of literature on this subject, the first step to integrating active feedback teaching would be to assess the effect of interventions that improve the quality of providing and receiving feedback.

Disclosure

The authors report no conflicts of interest in this communication.

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