



Good conversations, fairer feedback:

A qualitative research study into the perceived impact and value of feedback for doctors in training.

Dr Alice Rutter and Dr Catherine Walton
GMC Clinical Fellows 2019–20

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With a huge thank you to all the participants who so willingly gave up their time to share their experiences with us. Without their honesty and generosity this report could not have been possible.

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1. Executive summary

Purpose

Feedback has emerged as a key theme through the [external reports commissioned by the GMC](#) as part of the Supporting a profession under pressure programme. The reports highlighted feedback as an important factor in training, development, belonging and wellbeing. It is a key component of professional development for all doctors.

What is the impact of feedback experiences for doctors in training? What are the enablers and barriers to effective feedback? Through better understanding, we hoped to identify strategies for improving feedback for medical professionals and consider how feedback could be best utilised to positive effect – as well as to identify challenges that may need to be addressed.

Van der Ridder, Stokking, McGaghie and ten Cate (2008) define feedback as 'specific information about the comparison between a trainee's observed performance and a standard, given with the intent to improve the trainee's performance'. For the purpose of this work, we aim to explore doctors in training (trainees) and their trainer's experiences of 'feedback' - the formative discussion between individuals with the objective of reviewing an interaction, procedure or process, that happens on a day-to-day basis in clinical environments, with a view to improving a trainee's performance. Feedback on interactions and observations in the clinical environment may offer a reflection of real-world practice and contribute a different perspective. Given the broad reaching impact of feedback, we felt that a more detailed understanding of the perceptions of feedback in medical training would be of value.

Approach

We developed a research proposal and consulted with internal and external stakeholders to establish the scope of the questions. This included speaking to experts in the use of

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language in feedback, postgraduate deans, and feedback trainers. Through these discussions, we developed a research approach.

1. Systematic search and narrative synthesis of existing literature.
2. Semi-structured interviews, with purposive sampling to ensure capture of a range of perspectives. We interviewed 13 doctors – from a range of backgrounds and experiences: from foundation trainee to consultant, working within a wide geographical spread within the UK, and with almost half having a non-UK Primary Medical Qualification. We undertook thematic analysis and the themes emerging from the interviews were then compared to the literature.

Key findings

- Appropriate feedback:
 - helps to build trusting relationships and establish a positive culture.
 - Builds a sense of psychological safety that allows trainees to develop, engage, and promotes patient safety; poorly delivered feedback impacts on asking for help.
 - Helps develop clinical performance, confidence in skills, and is linked to career choices.
- Trainees want support in being able to work out for themselves how they can improve.
- A lack of feedback leaves trainees feeling disconnected and insecure.
- All interviewees felt negatively about some feedback experiences: more than one trainee considered leaving medicine as a result.

2. Introduction

Feedback to doctors in training can be utilised both as a part of summative or formal assessment, and as a formative process. The use of formative feedback between trainers and trainees is wide-ranging and covers most areas of clinical practice. For example, clinical skills, communication and professionalism. Formative feedback is a key component of professional development for all doctors and plays a particularly important role in postgraduate medical education where it forms the bedrock of medical training. There are varied and frequent opportunities for feedback in a training environment. Feedback on interactions and observations in the clinical environment may offer a reflection of real-world practice and contribute a different perspective to that of formal assessment.

This project aims to review the current use of feedback in postgraduate medical education, and to understand the value and impact of feedback practice for both doctors in training, and trainers. The assessment of the potential value and use of feedback is timely. It aligns with the recommendations of two key independent reports commissioned by the GMC from the Supporting a profession under pressure programme, *Fair to refer?* (Atewologun, Kline, and Ochieng, 2019) and *Caring for doctors, Caring for patients* (Coia & West, 2019). This programme aims to identify and address issues that have been raised to the GMC about the impact of working environments and system pressures on medical practice.

Fair to refer? (Atewologun et al., 2019) examined the disparity in referrals of doctors to the GMC by ethnicity. One of the recommendations of the report was the introduction of a UK wide framework and standards for the provision of feedback; employers who train staff who lead, manage, supervise or educate doctors to give and receive feedback should ensure that they are equipped to have difficult conversations; and to understand how bias influences giving and receiving feedback. *Caring for doctors, Caring for patients* (Coia & West, 2019) examined the impact of working environments and system pressures on the wellbeing of doctors. Included in the recommendations was that 'systems and frameworks for learning, training and development promote fair outcomes... and provide opportunities to improve and evaluate performance prior to high stakes assessments'. Further, the conversation around how to make feedback meaningful and supportive is gathering traction, and the perceived frustration at current feedback requirements is being discussed publicly (Kelly,

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2019). This distils down to a conversation about the usefulness of feedback, and a desire for feedback to improve.

Aim

To gain a depth of understanding of the impact and value of feedback for doctors training in the UK. To capture what makes for good quality feedback, and what might facilitate and inhibit this.

Research questions

1. What factors impact the perceived value of feedback in doctors' training?
2. What is the perceived impact of feedback on doctors in training?
3. What barriers exist that stop what would be perceived as *high-quality* feedback? (High quality was taken as 'useful', 'valuable' or 'impactful')

Research approach

We adopted a two phased approach:

1. systematic literature search and narrative literature synthesis
2. qualitative research through semi-structured interviews.

This approach allowed us to consider existing research and expert commentary in this area and identify where there were gaps in the literature. We sought then to build upon this existing knowledge, to offer a greater depth of understanding through focused interviews. Furthermore, we sought to expand on the findings of *Fair to refer?* (Atewologun et al., 2019) by purposive sampling. This allowed us to consider individual experiences and perspectives in great depth, facilitating our understanding and allowing us to reflect on the commonalities and differences between trainees.

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3. Literature review

3a. Methods

Information sources and search strategy

A systematic electronic search was conducted using Medline and HMIC (Health Management Information Consortium) with support from Cardiff University Library Services. The search strategy for Medline included the terms 'formative feedback', 'education', 'medical', 'continuing', 'graduate', 'mini-CEX', 'evaluation', utilising the 'OR' operator. The search strategy for HMIC used the terms 'feedback', 'postgraduate', 'medical education', 'junior medical staff', 'effectiveness', 'evaluation', 'appraisal', 'mini-CEX', 'assessment'. The searches were combined using the 'AND' operator. The reference lists of relevant search results were screened by hand for additional studies.

Eligibility criteria

Original research, expert opinion and review articles were included. Limits applied included publication in the English language and published within the last 25 years (searches were undertaken in December 2019). Debrief / debriefing, simulation, multisource feedback and studies not in the English language were excluded. The rationale for excluding multisource feedback was related to its use as a summative (pass or fail of ARCP) tool, and relied on anonymous feedback rather than an interaction.

Study selection

Results of the systematic search were screened based on the adherence of their titles to the eligibility criteria (CW) (low threshold to include, all uncertainties included). Titles and abstracts were then reviewed by both authors (AR and CW) for adherence to the eligibility criteria. Articles deemed appropriate or requiring further clarification were retrieved for full-text review. Following review and consensus (AR and CW) a final list of studies to be included was then determined.

3b. Results

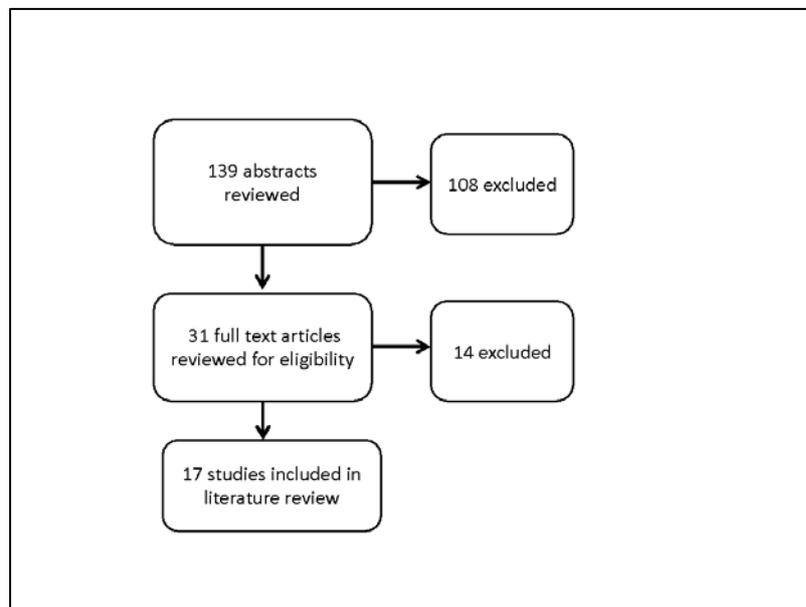


Figure 1: Results of search strategy

Consensus opinion was reached that 17 studies met the criteria for inclusion in the literature review – namely that they focused upon the *impact and value* of formative feedback for doctors in training. Five were qualitative research studies, 8 were systematic or narrative reviews, and four were expert opinion or evidenced-based summaries. Further information about these studies can be found in Appendix 1.

3c. Narrative literature synthesis

An objective and comprehensive analysis of the current evidence available

Impact of feedback

Educational impact

Doctors in training consider feedback as an important part of their professional, technical and career development (Kamali and Illing, 2018). However, objective evidence of positive impact on behaviour and performance is limited (Miller and Archer, 2010). Trainees use verbal and written feedback to identify and address educational needs; 76% of trainees

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report that feedback from work-place based assessments helps them identify areas where development is required (Alazzawi and Berstock, 2019). But, the choice of cases on which they receive feedback, by the trainee, can undermine the usefulness of feedback due to avoidance of areas they feel less confident in (Alazzawi and Berstock, 2019). Furthermore, a reported reluctance from trainers to deliver critical feedback means that trainees can struggle to get constructive and honest feedback (Scarff, Bearman et al., 2019). Scarff, Bearman et al. (2019) linked the reticence to deliver negative feedback to trainees as part of a wider cultural issue within medicine as a 'reluctance to reveal errors and shortcomings'. They suggested that training assessors with assessment and delivery needed to be matched with trainees learning how to incorporate feedback into practice.

Patient care

Beyond the impact feedback had on skills and performance, there is even less available evidence regarding the objective impact of well-delivered and received feedback on the care provided to patients. Kelly and Richards (2019) comment upon the impact of a lack of feedback; whereby the lack of reinforcement of good performance, with poor performance being left uncorrected, will be at the expense of patient outcomes. Where there does seem to be noted benefit is in the use of feedback as a part of debriefing processes to place negative events in the appropriate context (Watling, Driessen et al, 2012a).

Career trajectories

While multiple papers report that feedback has an impact on career choices, there is limited exploration of the way in which feedback does this. Implicitly, this seems to be through positive feedback stimulating or reinforcing a belief that a given career choice is a positive one (Kamali & Illing, 2018).

Individual level

For the individual trainee, receiving feedback was associated with increased job satisfaction (Cowan, 2001). This was despite the limited evidence of usefulness of the feedback that was received (Miller & Archer, 2010). Kelly and Richards (2019) found that feedback had a significant impact on knowledge and skill development, and Kamali and Illing (2018) found that positive feedback aided progression of learning, motivation and performance. Conversely, negative feedback was found to negatively affect performance and wellbeing.

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(In this context 'positive' and 'negative' feedback referred to content of the feedback as opposed to its delivery).

Value of feedback

Usefulness and value

Within the literature, it was difficult to differentiate between the actual and perceived usefulness of feedback, as there is little objective data (Lörwald, Lahner et al., 2018; Miller and Archer, 2010). However, there seems to be a clear link between satisfaction with training posts and receiving what trainees perceive to be useful feedback (Cowan, 2001). The value attached to feedback is in part related to its usefulness, such as the ability to translate it to action, but also relates to factors such as the weight people attach to the opinion of the individual offering feedback (Watling, Driessen et al., 2012a). As much of the literature focuses on perceived usefulness, the value that feedback is assigned by trainees and its use are closely linked.

Factors influencing trainee perceptions of value

Participants

The interaction between the trainee and the person offering feedback is important in terms of how the feedback is received and the weight that the information is given (Watling, Driessen et al., 2012a). Multiple reviews found that where the source of feedback is deemed credible, and there is an alignment of the personal and professional values of both giver and receiver, feedback is considered more meaningful (Watling, 2014; Kamali and Illing, 2018). These reviews suggested that credibility was assigned to respected senior members of the department who were trusted. Positive (in content) feedback was given particular weight if it was seen as scarce from a given individual (Kamali and Illing, 2018). Given the importance of relationships between individuals for the usefulness of feedback (Lörwald, Lahner et al., 2018), it was felt that rapid rotations in existing training structures could undermine the ability to use feedback as a tool for training (Watling, 2014).

Assessor engagement is a good predictor of trainee engagement and influenced the perception of the feedback message (Scarff, Bearman et al., 2019). The engagement in the educational process includes ensuring that there is enough time for discussion and making

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sure that there is an alignment of expectations around the purpose of observation and feedback (Castanelli, Jowsey et al., 2016). This alignment of purpose is particularly important due to the different approaches individuals take to giving and receiving feedback, and the potential negative impact of giving feedback that does not align with the individual regulatory focus (Watling, Driessen et al., 2012a; Watling, Driessen et al., 2012b). ('Regulatory focus theory' (Watling et al., 2012a) suggests that there are two systems that regulate human motivation: promotion focus – [associated with] aspirations and accomplishments, and prevention focus – [associated with] obligations and responsibilities. Watling et al., (2012a,) propose that this can explain a variable response to feedback).

Understanding motivating drivers

A key theme within the literature is the impact of the individual's regulatory focus on the information that they are seeking when requesting feedback from others, and how they interpret information given as feedback. The literature suggests that there are two different paths; actively seeking positive reinforcement versus the avoidance of negative or critical feedback (Murdoch-Eaton, 2012; Watling, Driessen et al., 2012a; Watling, 2014). Individuals may take different approaches to different tasks (Watling, Driessen et al., 2012b). Individuals tend to seek information that reinforces existing views, and the consistency of feedback – in terms of information received and the way it is delivered – influences the cognitive response to the information given and the consequential impact of the feedback (Murdoch-Eaton, 2012).

Context

How feedback is received, interpreted and used vary depending on both the individual, their drivers and value systems, and the wider context and culture within which they are working (Watling 2014; Lörwald, Lahner et al., 2018). Feedback is the product of a learning culture, which Watling (2014) argues is under-developed in medical training. He argues that the absence of a learning culture in medicine limits opportunities for honest feedback and how effectively feedback is used. This is further compounded by high turnover of trainee-trainer relationships in medical training, which undermines the importance of developing relationships and trust for effective feedback (Pelgrim, Kramer et al., 2012). A reluctance to deliver negative feedback was a common finding (Watling, Driessen et al., 2012b; Scarff, Bearman et al., 2019). (In this context 'negative feedback' was interpreted as negative

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content of the feedback itself, as opposed to the mode of delivery). This seemed to be related to a reticence to cause upset or awkwardness on behalf of the feedback giver. However, this may be compounded by the way in which trainees seek feedback, with feedback often being sought where trainees select the cases and so know that they will perform well. The objectives of trainees in seeking feedback can differ but in many instances were found to be motivated by a desire to reinforce what trainees already know (Scarff, Bearman et al., 2019). A culture of giving feedback that trainees need rather than that they may want is important, but the literature suggests that this is impeded by the perspectives and behaviour of both trainees and trainers (Scarff, Bearman et al., 2019).

Content

Feedback was considered more credible if it was timely, actionable and specific (Kamali and Illing 2018). Watling, Driessen et al. (2012a) and Kelly and Richards (2019) found that feedback was most effective when it formed a natural extension of the learning activity, and that central to this was the trainee's own reflection on the event. The feedback given by the trainer then enforced the trainees' own reflections. This was found to be more readily achieved when there were specific objectives to measure against (Castanelli, Jowsey et al., 2016). Watling, Driessen et al. 2012b found that positive feedback was interpreted as meaningless when it focused on skills and knowledge that trainees felt they should already have. Instead, they felt that feedback was more valuable when it was around an activity or event that the trainee considered meaningful (Hauer and Kogan, 2012; Watling, Driessen et al., 2012b). Where feedback included comments that were felt to be personal or derogatory, the value of the feedback was undermined (Kelly and Richards, 2019).

Delivery

The literature has conflicting views on the favoured format of feedback. Scarff, Bearman et al. (2019) found that trainees valued verbal, qualitative feedback over more formal and/or quantitative written feedback. Trainees felt that the verbal, qualitative feedback offered a greater depth of understanding, in particular about how to action points for development. However, Saedon, Salleh et al. (2012) and Setna, Jha et al. (2010) found that the majority of trainees derived their learning objectives from the written feedback that they received through workplace-based assessments.

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Lack of time to dedicate to feedback and assessment was cited as a key factor in poor quality or low availability of feedback for trainees, and as a barrier to educational engagement (Castanelli, Jowsey et al., 2016). Alazzawi and Berstock (2019) found that a lack of time meant that feedback given was more superficial, and less useful. The assumption is that this is due to competing pressures for the individuals involved, (such as a conflict between clinical and training commitments), but why time is constrained was not specifically explored.

Building on the evidence from the narrative review: next steps

In summary, key findings from the literature were that trainees value feedback and it improves satisfaction with training posts. However, there is a reluctance from trainers to deliver negative feedback. There is little firm evidence of relationships between feedback and performance, quality of patient care, or career choices – and these are areas that need further exploration. Aspects of the interaction (for example, the perceived credibility of source, relationships and alignment of values) make feedback more meaningful. In the same vein, understanding the motivations of a trainee to seek feedback will improve the interaction, and its perceived quality. There were mixed findings for the delivery of feedback, and a lack of time was cited as a barrier to educational engagement, with further understanding of enablers and barriers to good quality feedback required.

The second phase of this project was to build upon the findings of the literature review to further explore the issues identified through focused interviews with doctors. Improving understanding and clarity about the factors that increase the value of feedback are needed in order to support recommendations for further training in giving and receiving feedback. The impact of feedback experiences in relation to trainee performance and career choices was another area where further evidence was required. Acknowledging the broader context of this work, in particular the findings of *Fair to refer?* (Atewologun et al., 2019), was key. Therefore, the aim was to ensure a broad range of experiences was listened to, in particular from the perspective of doctors with protected characteristics.

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4. Qualitative interviews

4a. Approach

As the aim of this research was to gain an in-depth understanding of perceptions of feedback and its impact on trainees and their training, we adopted a qualitative approach. This approach allowed greater exploration of the concepts around feedback and offered the opportunity to gain greater insight and understanding of trainee experiences. We utilised the 'Kitto criteria' for qualitative research as a checklist at each stage to help assure the quality of the research (Kitto et al., 2008).

Philosophical underpinnings

We adopted a constructivist approach, which reflected that while there may not be a single perspective that was the right one – or a single truth – it was the perceptions of impact and meaning that derived greatest interest. We felt that we would be best able to capture these perceptions by eliciting the participants' view of reality, best captured through the constructivist approach. This aligns with the approach outlined by Teherani et al. (2015) "constructivist researchers believe that there is no single reality, but that the researcher elicits participants' views of reality".

Theoretical underpinnings

We adopted a constructivist grounded theory approach, allowing themes to emerge from the data. While the literature suggested some areas that related to the research question, we did not have confidence that the data was complete. We also sense-checked the literature against our own experiences, and informally against the experiences of our peers through discussion. For this reason, we chose to take a more open approach and allow the themes to emerge from the data rather than drawing on preconceived assumptions (Teherani et al., 2015). We hoped that this would offer greater insight into the key areas within this field of study and would create a framework for further detailed exploration.

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Ethics

Utilising the Health Research Authority framework, we established that the research proposal did not require NHS Research Ethics Committee review in any of the four nations of the UK (HRA, 2020). The proposal, along with all research materials, were submitted to the GMC's external research review process (GMC, 2020). Amendments were made on the basis of external review suggestions, and the GMC Research department were content that the review undertaken was appropriate to the ethical risk posed by the study.

Participation was voluntary, with the option to withdraw for a grace period after the final interview (deadline 30th June 2020). Consent was sought before the interview, clarified again before the interview commenced, and a pre-agreed statement around the intent and purpose of the research shared with all participants. Participants were asked at the end of each interview whether they would like to withdraw their consent for inclusion.

4b. Methods

Research design

Sampling methods

We used a combination of snowball and purposive sampling, to ensure that we were able to capture a range of experiences including:

1. different countries of the UK
2. different specialty training programs
3. different stages of training
4. trainees with protected characteristics, including disability, gender and ethnicity
5. trainees who qualified overseas
6. the trainer perspective.

These were all features that had been identified through review of the literature, discussion with area specialists, such as at NHS Education for Scotland, as well as internally within the GMC, and through external independent reports as impacting on experiences of training and

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feedback. Relevant independent reports included the *Caring for doctors, Caring for patients* (Coia and West, 2019) and *Fair to refer?* (Atewologun et al., 2019) reports, commissioned by the GMC.

Participants were approached via email invitation, through existing trainee networks, specialty groups, and forums; including a specialist forum for doctors with disabilities. Trainees were invited to contact the research team to share their experiences, both positive and negative, and upon expression of interest were sent a more detailed email explaining the research outline and what they could expect. Participants were asked to read and sign a consent form prior to meeting with a researcher, and this consent was re-clarified on the day with the help of a verbal prompt contained within the interview guide. All participants were asked to share the research project details with other trainees that they felt would be interested in participating.

Data collection and coding

We conducted semi-structured interviews by telephone with participants across the UK. As we intended to take an inductive approach, the questions were left as open as practical. With the participants permission, the discussion was recorded by verbatim notes taken during the discussion which were then transcribed and stored on a central secure database. Contemporaneous memos were produced by each researcher but kept private so as not to influence the approach.

Analysis

We adopted a constructivist grounded theory approach to coding, as described by Tie et al. (2019). Both researchers reviewed all the data independently and coded words and phrases. These were compared to other initially coded data points and categorised into emerging themes. These themes adapted and developed as data collection continued. We followed a three-phase coding approach, as described fully in Appendix 2.

We used a 'storyline' approach to allow integration and cohesive presentation of the data, in a way that maintained integrity and allowed the exploration of meaning. The separate storylines that were developed, such as around the role of relationships and the impact of psychological safety, were woven back together to develop a comprehensive theory. For full detail of data collection, coding and analysis, please refer to Appendix 2.

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Researcher impact

Both researchers are working at the GMC as leadership fellows and are also doctors in training – and an active part of the clinical community. As we each have our own experiences of feedback through medical training, we were conscious of not projecting our views and pre-conceptions on to the data given by our participants but are aware that it is impossible to eliminate this influence. However, we felt that our contextual understanding of the concepts and environment that were being described as well as approachability as ‘peers’ rather than external to the community offered us the ability to gain a greater depth of understanding.

Links to external theory

We reviewed the themes that emerged from the data against those that emerged from the literature, to establish whether our data is in keeping with other work in this field.

4c. Results

We spoke to 13 trainees over the course of three months, with between 45 minutes to 90 minutes for each interview. Table 1 shows the demographic data of the interview participants. Effort was made to reflect the demographics of participants to that of the Medical Register – which shows a higher proportion of female doctors and doctors with a non-UK primary medical qualification joining the register (GMC, 2019).

Demographic data (Table 1: demographic data interview participants)

Demographic data	Participants (n=13)
Female	8
Primary Medical Qualification (PMQ) from a non-UK medical school	6
Trainer role*	8
Disability	1
Black, Asian or Minority Ethnic Group	8
Country of postgraduate medical training	
England	6

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Scotland	3
Wales	4
Stage of postgraduate medical training	
Foundation	2
ST1-3	1
ST4-8	6
Consultant	4

*for the purpose of this work 'trainer' could vary from a consultant educational supervisor to a senior trainee within a team. Trainers in both formal and informal roles.

4d. Thematic analysis

Through thematic analysis the data was categorised into themes and sub-themes, based on areas of commonality and shared content across the interviews.

Impact of feedback: educational impact

Learning and patient care

The impact of feedback experiences on trainee learning and development – and therefore on performance and career progression – was wide ranging, but common themes did emerge. Feedback seemed to have a significant impact around points of transition, “regular, formal feedback encouraged [the trainee] to take on consultant role...eased transition from reg[istrar] to consultant” (Participant 1); felt “nurtured and encouraged in a route to becoming a consultant” (2). Feedback was felt to aid learning and improve self-confidence: “It helps with learning; it helps me improve my confidence. It offers reassurance. It encouraged me to keep going, to keep learning” (8). Feedback acted as a form of ‘benchmark’ and trainees being given direction and reassurance about their development was a clear theme – “Feedback gives me a clearer view of where I’m progressing, [without feedback] it can be hard to know how you’re doing and that can make you feel untethered”(8). The impact of feedback on self-perceived performance emerged, in the main through increased confidence, “[the consultant] was positive, he never criticised, and I got better” (11). One trainee reflected “it takes a lot of positive feedback to support and build confidence” (7).

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Experiences of negatively or poorly delivered feedback appeared to have the effect of trainees withdrawing from training opportunities, “she stopped doing clinics with that consultant, so it affected [her] training” (7). Or losing confidence, impacting on self-perceived skills, “I believed the negatives. My work got worse, and I couldn’t understand why” (13).

Participants described the lack of feedback as [it] “impacts on my training, and I don't get the training or experience because I cannot learn” (6), “Without feedback I feel like I am swimming in this big ocean not sure if going the right direction” (4). Participants described situations whereby trainees were being “left to it [with] no feedback allowed someone to continue poor practice, without being taught properly” (2). Without feedback there was “no insight into their technical difficulties” and by “ignoring underperforming trainees, it comes to a head at formalised assessment and then it is unexpected” (1), “things get missed, they grow, and they become a bigger problem. We need to know, specifically, what we need to change” (11). Trainees also reflected that negative experiences of senior doctors when asking for feedback or help hindered ongoing development and patient safety, “if you know you will need to go through great effort to ask the right questions it impacts the safety of your patients, as you will be less likely to ask” (7).

Career trajectories

Most participants described positive feedback (in both content and delivery experience) received as a trainee as a significant factor supporting decisions around choice of speciality “[I chose my specialty] much due to the level of feedback given as a trainee. I like this and others are telling me I'm good at it” (1); “I chose... due to a tutor taking an interest in me, my development, regular constructive feedback” (4). Well delivered feedback is a form of positive reinforcement, feedback and praise impacted career direction. “[It’s] direction of where they think I'll be good at. Unless someone tells you that you come across as skilled in a certain area - you don't know” (6). From the perspective of a trainer or supervisor, it was noted that feedback has a role in supporting trainees to make choices about their careers “there is a reticence to question the trainees’ choice ... it’s a hard decision 'this isn't for me'. Feedback here would help” (1). Therefore, well delivered constructive feedback could support a trainee to decide that a particular career is not for them.

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Positive feedback experiences can support an individual's sense of belonging, or "fitting into" (5) a role or speciality emerged. "The more feedback I get, the more involved I would feel and the more interested I would be in a speciality" (6). However, other, more negative experiences also occurred: "The counter is that poor feedback can make you think... I don't want to work here. I don't want to be a part of this, I don't like this culture" (9). Negative and discriminatory experiences had a significant impact "I nearly decided to quit" (4). "It's always stuck with me. It put me off doing that specialty, I didn't want to spend more time being treated that way" (11). Negative experiences were perceived as more influential at "earlier points in the career such as F1 / F2 and core training, this is when the feedback is delivered can most impact upon career choices" (12). However, some trainees reflected that negative feedback experiences also gave individuals a drive to succeed "...perhaps makes them more determined, they want to succeed to prove to someone you can do something, prove someone wrong, given a drive" (10).

Emotional and psychological impact, feeling safe

The emotional and psychological impact of feedback experiences was raised by all participants. Positive feedback experiences allowed trainees to feel "valued" (3), "nurtured and encouraged" (2). The emotional response to good feedback "is uplifting, you are understood" (6). Being able to consider emotional responses to events was acknowledged as an important factor in the delivery and receipt of feedback. "[It's] important that we help people to understand their emotional responses. Feedback conversations are a really good way to do that" (8) and "helped me cope to understand and process" (3). Note that the experience of receiving the feedback in this way was described as a positive experience, whether the individual received praise or developmental comment.

Phrases such as "comes straight to mind" (11) "one that comes to mind because I'm still angry" (13) in relation to negative experiences suggested that some could not 'forget' these experiences, they were imprinted. Language used explored the idea of being 'damaged': "damage has scarred, confidence issues have never gone away" (4), gives a sense of the experience of a traumatic event, with lasting effects, such as feeling "paranoid" (4) and "destroyed" (6).

Participants described the impact of negative feedback events as "feeling embarrassed" (2), "undermined" (4), "worthless" (6). Trainees "endured these situations" (7). The longer-term

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impact of such negative events included feeling low in mood and a difficulty in focusing on work: “When you feel low you cannot study, and cannot improve, and therefore constant negativity going around is very hard to overcome” (6).

Psychological safety can impact upon the effectiveness of an individual's work, team working and ultimately patient safety therefore the impact of feedback experiences is an important one. “It should feel safe to say whatever you want” (7), “she still looks to me for support, but she feels safe” (13). The experiences of not feeling safe were evident – “I wasn't valued and I wasn't safe.... when you're out of your comfort zone, that's when they're hostile.... you feel intimidated and afraid” (8). Trainees described feeling on edge, waiting for the next difficult comment: “Anxious about who was going to criticise me next” (4) and “[feedback].... destroyed an individual. Bad experiences can be traumatic and painful” (6). Not feeling safe can contribute toward significant impact and learned helplessness – “I became what they said I was. I believed the negatives” (13).

Language used to describe experiences:

Confrontation and defence

In the context of describing what constituted useful feedback, trainees used emotive language of confrontation and defence when describing their negative experiences. It was suggested that “slamming the feedback down” (12) was unhelpful. The concept that feedback was physically weaponised emerged: – “I felt ambushed” (2), “It was brutal...”(3), “used as ammunition” (6), “[I found] the way to defend myself” (8). Reputational damage as a result of feedback known to the wider department is also described in such terms, having “destroyed an individual” (6), and being difficult to recover from.

Trainees with a primary medical qualification (PMQ) from a non-UK medical school discussing their experiences of feedback used particular words to describe their feelings, which they related to being a non-UK medical school graduate– “hostile, intimidated... afraid” (8), “a scapegoat, if you are foreigner can be more difficult”(6), “beaten down with words...it can be demoralising” (6). “....if you show weakness, people descend on you” (6), “as a black person, no matter what I say, no matter what tone or voice I am speaking with, it is always interpreted as aggressive – as intimidating” (13). “There is a lot of bias, often unconscious, but as soon as you suggest that might be a factor people get really defensive”

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(13). This was not the experience of the trainees interviewed who had a UK PMQ, irrespective of ethnicity.

Justice and fairness

When discussing feedback that was perceived positively, or that was desirable, participants used language around justice and fairness. Feedback that was perceived as *fair* was highly prized.

Reflecting upon questions regarding positive experiences of feedback, and the characteristics of useful feedback – participants used words such as “non-judgmental” (4), “fair, honest, without bias” (6), “willing and open to engage” (13). The impact of fair and just feedback was also communicated through the participants’ language – “Fair assessment is uplifting” (6). Trainees described their frustrations at perceived injustice and inequality: “Things were unequal...if you were one of them, they would support you. If you came from outside, you were just occupying a number” (13).

There was a strong desire for feedback to be justified, through evidence and accountability. “...only what you have seen personally” (1), “based upon personal observation” (2) “verify why” (4), “substantiate with evidence”, “aware and accountable” (6). One trainee asked the question “Where is the accountability?” (7). This was caveated by the feeling by some trainees that the feedback they received was unfair, and unsubstantiated, and this seemed to move them toward language more commonly used in a court of law - “able to defend” (4), feedback “not evidenced” (6) “witnesses present” (4).

Factors influencing trainee perceptions of value:

Relationships, trust and engagement

Feedback seemed to be influenced by, and impact on, relationships at both the individual and departmental levels.

A positive relationship increased credibility and weight of feedback, “[with a] good rapport, good relationship... you hold what they say in higher regard”(3), “Feedback delivered from a person I respect, look up to ... means a lot more” (10), “[if you] respect their clinical opinion, [you’re] more willing to accept their opinion is relevant to you” (12). This aligns with what

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we heard from trainers, “as I have become more senior, now nearly a consultant, people give more weight to the feedback that I have given. They value my opinion more” (9). This is in direct contrast to the experience of individuals in the supervisory role who described difficulties delivering feedback to colleagues of a similar training grade “I don’t think the feedback that I gave really had any impact” (11). Trainees felt that a good relationship was particularly important for ‘negative feedback’ (in this context feedback that constructively helps a trainee recognise areas of development). “You need to have a good relationship to be able to give negative feedback” (9) and reflected that developmental feedback should be “kind and compassionate. I know why you are doing this, and I understand, but have you considered...” (10).

The data highlighted the importance of feeling valued by the person offering feedback, “they have invested in me, taken time to know me, understand me. It has been personalised, not a tick box exercise, they have taken the effort to understand you. Kind about feedback, invested, mutual respect”(10), and that this positive interaction was more likely to encourage them to seek feedback in the future “once you know who is a good person to work with you go back to the people who make you feel good” (11), “I also feel more confident to put myself forward and highlight my needs” (7).

As a counterpoint, trainees also felt that a lack of relationships impeded their ability to get useful feedback, “how can trainers be able to give meaningful feedback when they hardly know you? The relationship and the trust are what mean that someone can give you meaningful feedback” (9), “I am not one of them... I realised that no-one would help me, that I was on my own, I learnt to be very self-sufficient” (13).

Feedback was a tool for developing relationships and trust in the professional setting, “If you give feedback well, realistically, honestly, people know you are genuine. They will come to you for help if they need it” (7).

Negative feedback experiences impacted on relationships, and made trainees feel less able to ask for help “I was publicly being shamed in front of the whole team. It was demoralising and affected my relationship with that consultant. I know they wouldn’t support me” (7), “my team can be very condescending and treat me like I am dumb. [This makes me] feel I cannot talk about patient care which is very frustrating” (6). Several trainees reported public ‘shaming’ experiences, and there was a consistent view that “critique on action in

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front of others, in particular patients - made you feel awkward, inadequate and embarrassed” (10). There was a view that public ‘feedback’ was often “criticism dressed up as feedback” (3) rather than intended to benefit the recipient.

Understanding motivating drivers and barriers:

Attitudes and approaches

Trainers discussed their motivations around feedback, “I really wanted to take the time to understand the trainees needs” (7), “it is important that we help people to understand their emotional responses” (8). Trainees reflecting on the attitudes of trainers valued those who showed interest and commitment to the individual trainee, the trainee’s educational journey, and the quality of the training the trainer was delivering. “He had an interest in education as a background, and cared about the way in which he trained, [he]lived, breathed, trouble-shooted” (2). However, challenges were highlighted that impact upon the quality of the feedback delivered, such as lack of first-hand knowledge of the trainee’s practice – “the educational supervisor doesn’t work directly with trainee therefore it’s difficult to compare” (1).

The challenge of separating the individual from their work when giving feedback was commented upon. One trainer told us, “you are trying to give feedback on an individual episode rather than on their general personality or demeanor” (12), but trainees reported encountering the opposite of this, “people will give you negative feedback if you are not convenient for them – if you make life difficult or challenging for them. Because they feel it reflects on them...” (11), “There is a lot of bias, often unconscious, but as soon as you suggest that might be a factor people get really defensive. They can’t acknowledge it...my experience has been that most people are prejudiced in ways that they don’t realise “(13). Reported experiences of trainer bias were strongly reported by trainees with protected characteristics.

Barriers to high quality feedback

Through the data several barriers to engaging with effective feedback emerged. Key among these was a reluctance to give difficult feedback, perceived constraints on the ability to give and receive honest feedback, and assumption that feedback was only required in the

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context of 'negative' (developmental or constructive) feedback. Trainers reflected that their past experiences of both giving and receiving feedback affected their feedback approach. Data suggested that the absence of feedback led to uncertainty and insecurity for trainees.

Trainers said that there was "temptation to ignore, [issues that are] difficult to confront" (1), and expressed uncertainty about giving difficult feedback "[I felt] my opinion doesn't matter... the cognitive load was too much" (2). They felt fearful of the ramifications for themselves, "I don't want to be accused of bullying" (1), "way too much paperwork and too much of a headache. It's too hard to be honest" (9). Trainers can feel "fearful of complaints" (4). "I don't like giving negative feedback, inherently don't want to upset, perhaps a bit selfish - but don't want to upset or distress, perhaps would be more selfless to give the feedback in the long run - I don't enjoy giving harsh feedback" (10).

Trainers felt mindful of avoiding possible negative impact on the trainee: "You don't want to leave people feeling hopeless" (7), "I should have gone to her supervisor, but didn't want a formal complaint" (13).

Trainees had a perception that feedback was an inconvenience, "[the] default position is to see feedback as a burden... [a] tick box exercise" (3). This seemed to be due to lack of time, "rarely felt that there was protected time"(3), "not taking the time"(12), "availability for formal sit down feedback is sometimes limited"(9), as well as lack of engagement due to competing pressures "tick the box but they don't help you – they don't explain to you, you can't learn because they have no time" (7). A wider system or departmental knowledge of a trainee's skills would usually be overseen by the Educational Supervisor, however, this would "require an active enquiry about the trainee" and therefore there may be a lack of awareness of a trainee's difficulties from the educational supervisor perspective too, with the role being described by one trainer as "onerous already" (1).

There was a sense that required assessments served as permission to ask for feedback. Trainee interest and engagement in receiving feedback is noted by trainers and can improve rapport and perceptions. "... they are taking an interest in the placement, [show] mutual respect" (10) "...if a trainee is receptive and interested in the feedback that's helpful" (12).

When feedback conversations did not go the way the individual had envisaged, this could lead to negative outcomes; "when you're trying to feedback to someone who wants to one up you... they get stuck on something that's not relevant and they ask you something you

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don't know" (7), "They rejected the notion that there was any problem, and instead turned it around and put all of the blame onto me. They had no insight" (9). Trainers reflected that "[feedback] can be difficult without an element of self-awareness. One particular trainee - people tried to give feedback, but he wasn't receptive to it, caused a lot of problems in the department" (12). There was a perception that "people get really defensive" (13).

Cultural barriers

For the purpose of this research, the Oxford English dictionary definition of culture was broadly considered - "the distinctive ideas, customs, social behaviour, products, or way of life of a particular nation, society, people, or period" (Oxford University Press, 2020). However, it is acknowledged that the term culture is widely used and can mean different things to different people, and in differing contexts. The culture of training environments was viewed as impacting engagement with feedback, potentially acting as a barrier where differences were perceived.

Cultural belonging

Many of the participants commented upon the sense of belonging, community or culture – and how that impacted upon their experiences of giving or receiving feedback. Multiple respondents described feeling like an outsider and not belonging "I am not one of them. If you came from outside, you were just occupying a number. I was always looked at as a foreign trainee" (13).

"People can be really hostile to those who are new, to those not in training. I don't want to say it's racist, but you're definitely someone who is not in the gang" (8).

"I'm an outsider, I'm older.... I feel there is bullying culture. I don't know how to interact with my consultants. I don't know what to expect." (6). One trainee reflected that she felt uncomfortable with "men of a certain age giving feedback to a 20-something female" and that traits where a male trainee would be deemed "confident ...[were] annoying as a woman" (2).

Feedback that was perceived as fair had a positive impact on trainees' sense of belonging: "Fair assessment is uplifting, you are understood, and part of a community... gain a passion for medicine" (6). While positive feedback experiences increased engagement, "Positive and

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well delivered feedback can be inspiring and encouraging, gives energy and motivation to proceed with a particular specialty or particular service area” (12), the opposite was also evident “poor feedback can make you think... I don’t want to work here. I don’t want to be a part of this, I don’t like this culture” (9), “it put me off that specialty...I didn’t want to spend more time being treated that way” (11).

For doctors new to the NHS the difficulty in gaining feedback due to a sense of lack of belonging seems to be particularly pertinent – with one participant discussing their experience. “In the beginning when we need support, when we’re insecure, you’re out of your comfort zone, that’s when they’re hostile. Once they get to know you it’s ok but when you really need feedback and input you feel intimidated and afraid” (8). One trainee described the ‘hurdle’ of understanding the culture of a hospital in order to get something done. When struggling at work, the senior told the trainee “always state you have tried once”, they realised “you needed the right phrase ready” (6). This suggests a social or cultural expectation, not explicitly stated or taught, that enabled getting things done and getting support. A sense emerged from the data that trainees felt their access to support, and fair and constructive appraisal of their performance, was impacted by certain characteristics, with one trainee reflecting that she felt that feedback she received was “mixing disability and performance” (4).

Workplace culture and gossip

‘Gossip’, ‘hear say’ or ‘behind the back’ feedback emerged as a significant sub-theme and was of interest due to not featuring in the literature reviewed. Trainee doctors were very aware of this alternative form of ‘feedback’ and felt it had a significant impact on their training, performance and reputation.

“gossip ...is actually another form of feedback, it’s how you find out what people really think about you...the gossip makes you out to be useless” (8).

The pitfall of gossip or preconceptions from the perspective of training was “[There is a] danger [they are] tarnished early” (1), one trainee described the impact on them: “he spoke behind my back, poisoned my reputation, and damaged my relationships and my training... It is difficult to ever recover your reputation” (13). One trainee reported “sneaky side comments by consultants but would not engage directly and ask directly what support [was] needed” (4). Others felt side-lined from the process “Everyone would be buzzing about it,

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but no-one would ever have a helpful conversation with me face to face.” (13). Trainees felt that problems became exaggerated or taken out of context: “glaring errors are talked about around the department; it’s hearsay, like gossip – and things get taken in the wrong way” (9). The ultimate impact was that trust in departments and teams was undermined:

“gossip... allegations not even close to what happened. [It’s] frustrating when you cannot trust your team” (6).

Trainees had developed different approaches to managing feedback received through departmental gossip. This included ‘sense-checking’ by discussing with colleagues or supervising consultants “You need a network to be able to bounce things off. I need to be able to take those flippant remarks to someone I trust and ask – do you think there is any truth in this? Reflection is a big part of being able to understand and use feedback” (9). One individual got to know a nurse on their ward who “said that you were confident and competent, but that people did not communicate their needs to you clearly and talked about you behind your back” (6). The colleague offered contextual insight.

Perceptions of difference

Cultural differences and divides were a barrier to engaging in feedback conversations.

“[Engagement with medical students] is this a generational or cultural difference? I struggle to relate to medical students as medical school so different [in UK]. However, being... longer in the UK has improved [my] understanding of what is going on.” (5). This trainee expanded on this further regarding the impact and usefulness of feedback: “Cultural, class, education and background will impact on how we relate... there is a barrier to the usefulness of feedback given” (5). The concept of interpersonal differences acting as a barrier to useful feedback was developed: “physical, spiritual, and racial differences impact on both giving and receiving feedback...most people are prejudiced in ways that they don’t realise” (13), “people are afraid to give me feedback because I am out of their experience. They think I will behave like the black woman they have seen on TV” (13). Some trainees discussed the wider culture of the NHS, and the impact of this on engagement with challenging feedback: “We are afraid to be vulnerable, a cultural issue of the NHS staff” (6).

Factors that impact usefulness and value

Framing

Trainees reported a benefit in signposting prior to discussing feedback. Specifically, this meant that feedback was more likely to be noted. “[When the trainer says] ‘I am going to give you feedback’ [I am] prepared mentally to receive...you pay more attention, more likely to take this [feedback] on and change what you do” (1). Trainees specifically referred to ‘framing’ of the discussion and found this impacted engagement and receptiveness: “Framing of the discussion at the start allowed free space to help me reflect and understand my experiences” and “The important thing is that you are both in that frame of mind and ready to invest.” (3). In addition to framing a discussion, setting expectations and aligning purpose was also deemed to be a key component of good feedback experiences. “You need to set the expectations” (7), “we’re both on the same page, and I know I’m there for my benefit” (3). The alignment of purpose allows the supervisor to “be on board, to know your needs and empower you” (7), and to build “mutual understanding ...the feedback isn't necessarily positive, but they understand where I am coming from” (10). This was particularly important when thinking about developmental feedback, “We were able to talk about her negative experiences and come up with a plan together” (13).

One trainer reflected that considering their experiences of misinterpreted intentions and comments made, “All conversations with trainees therefore could be deemed as feedback” (2).

Situation and timing

Timeliness of feedback was considered important. “If feedback doesn’t come until the end of the placement, things get missed, they grow, and they become a bigger problem. We need to know, specifically, what we need to change. it would be more effective, it would have more impact, if it was delivered at the right time” (11). By the time trainees reached ARCP (Annual Review of Competency Progression) feedback was felt to be of “no value... [I] could not remember panel discussions.” (2).

What trainees considered optimal timing was situation dependent. “Feedback needs to be delivered at the correct time, sometimes this will not be immediate, like after a difficult

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case, early in-depth analysis at the time not good, better done within a few days” (1), “If [it had been] said immediately would have been more valuable.” (5). “Feedback was built into the task it felt more natural” (3) – however, this contrasted to the experience of having “[a less constructive feedback experience] in the midst of an acute setting” (3). “The timing of feedback, especially in the context of a formative or negative experience, is so important” (3). It was apparent that there was no correct formula or agreed universal approach.

For some trainees, the timing aligned with the framing of the feedback discussion, and there was value in time to prepare and reflect in advance. This was seen as a value of routine scheduled interactions or requested feedback. “Timing [is] better when you have been prepared – such as once a month catch up with your Educational Supervisor - expecting feedback, and willing to share with each other, away from an acute environment, time to talk” (10). The clinical setting appeared to impact experiences, “in [secondary care] there rarely felt that there was protected time for feedback [in comparison to primary care]”(3). And the reality for many was that “the availability for formal sit-down feedback is sometimes limited, especially getting this regularly” (9). There was a sense of frustration at trainers “not taking the time to give the feedback... walking out the door and heading home” (12).

Content and language

Feedback was an opportunity for “spontaneous comment” (2). Feedback that had been “prepared, thought about structure and delivery... formalised around specific focus, and built on previous feedback” (2) was deemed more useful by participants. Trainees wanted feedback that was specific, relevant and actionable. “[We] talked about a specific aspect, a particular detail [such as] 'I like the way you spoke to the family', rather than a generalised comment” (11). “[Feedback] needs to be specific – with a roadmap for certain stages, with clear and concise points to address” (9). “Feedback should be balanced, focussed on what was done well, but also helpful suggestions for development... that the individual will have the opportunity to develop and improve on these things” (12).

The need for consideration of language and professionalism was noted “I’m brutally honest, but I am polite” (7). Circumstances where feedback was conveyed in an unprofessional manner, such as “unprofessional in the feedback. Joking about a serious situation, using unprofessional language” (12), were considered unhelpful.

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Communication and delivery

Consideration of the mode of delivery revealed mixed opinions. The idea that face to face communication helped ensure understanding of intention emerged; which email, or written content was felt to lack. “Email [is] not the best form of communication, needs to be face-to-face. Then the message is received as 'intended to be” (1). This did tend to be dependent on the purpose of the feedback – ranging from a discussion of a specific event, to acknowledging when a trainee had done a good job. A trainer reflected “when people do a good job...feedback by email is a record to be kept for portfolio” (2) and a trainee felt that written comments had value when “negative comments can be clarified and if needed rectified” (4), however this final comment seemed to be driven by a desire for accountability on behalf of the feedback giver.

The setting for feedback delivery was important, and in particular privacy. Trainees experiencing “critique on action in front of others, in particular patients - made you feel awkward, inadequate and embarrassed” (10), and felt that “not enough attention paid to avoiding negative feedback when witnesses present” (4). This was not just related to negative feedback: [if feedback] “is in front of others, it lacks element of confidentiality, even if positive feedback - feels embarrassing, comes at expense of someone else – [seen as] 'doing a good job' if in front of a colleague, does that mean that they are doing a bad job?” (10). This exemplifies the point that feedback that is either positive or negative in content can be poorly delivered and be a negative experience.

Giving the trainee the space to feel safe, to reflect and respond to feedback was deemed valuable by participants. “It shouldn’t be a ‘telling off’, it should be relaxing to reflect on things. It should feel safe to say whatever you want” (7). Without this, respondents felt there was “no real opportunity to respond to feedback and explain or get help to change” (4). The value of giving an individual space to reflect allows both the trainee and the trainer to “think about how and why an individual does something, it effects and encourages a behavioural change, not just simply telling someone to change” (11). Considering the “frame of mind of the trainee” (4) and having the flexibility to consider a trainee’s response during the feedback conversation were both considered of value “I had to backtrack on my planned conversation, due to points that were raised by the trainee” (10).

Delivery frameworks

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Participants all placed value on a two-way feedback conversation, the “developmental conversation” (12). This could be “built on previous feedback” (2) and allow “the space for open conversation” (3). The value of “regular ‘check-ins’ allowed [in more challenging clinical situations] an unfiltered download of that information and then I felt like our conversations helped me to understand and process it” (3). One trainer reflected, “It is important that we help people to understand their emotional responses. Feedback conversations are a really good way to do that” (8).

Most respondents valued conversations where direction, goal-setting or next steps were considered, “giving next steps, one step further. Most of the time you know what you are doing but need a point in the right direction” (5), “I want it to be objective setting, I want a simple goal that I can move towards” (9). The sense of shared responsibility of the feedback conversation was important: “We shared the responsibility the feedback discussion was really useful for both of us” (9). It was also reflected that a discussion helped clarify intention, coming across as “kind and compassionate. I know why you are doing this, and I understand, but have you considered....?” (10) with an effort on both sides to increase understanding.

The development of a feedback style tended to come from role modelling past experiences and was supported by training as an adjunct. “[I try to] emulate good practice, all modelled on one particular individual, and how this feedback was given by the individual” (2). Trainers that showed an interest in giving feedback had the greatest impact upon trainees’ future action “he had an interest in education as a background and that moulded my future feedback technique” (2). Trainers also reflected the idea that feedback is rarely ‘fed back on’; “... you are doing what you think is the right thing, but my opinion is not an evidence base. I want to not lose touch with whatever feels most genuine, but training is a useful adjunct” (7).

Many participants reported continuing to use feedback models, but also questioned the limitations of these. “I do end up delivering via feedback sandwich, workplace-based assessments almost encourage this style - what was good, what needs to improve. Inevitably what you end up doing in practice” (10). However, its value in reality was questioned, “[I’m] aware of feedback sandwich, it gave a bit of structure....not necessarily useful in reality, as people...don't react as predicted, need to be guided by response” (10). “Some people use the didactic models, driven by the deliverer. For me the reflective

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approach is what I feel most comfortable with (9)” “[Feedback] models can sometimes constrict what is being said. It can create a superficial experience. Really the important things are the discussion, the relationship, and the time” (3). (See Cantillon, 2008, for further information about traditional feedback models).

The value of an individual, or considered approach, tailored to the individual trainee and their needs was raised, from the perspective of aiming to not just feedback, but allow personal reflection and bringing about a behavioural change. “it becomes a discussion. You think about how or why an individual does something, its effects and encourages a behavioural change, not just simply telling someone to change” (10). This contrasts to participants reported experiences of both giving and receiving feedback, and the clear negative impact: “Not making it a conversation, slamming the feedback down, without asking or framing 'why was this a tricky episode' not a two-way process, no understanding of context, or getting relevant information” (12).

5. Discussion

Impact of feedback

There was no mention in the literature reviewed of the language that trainees use to describe feedback and their experiences. The language that was used by research participants suggested that feedback is perceived as a ‘battle’ like interaction, where there is a need to be on their guard. Feedback was described as ‘ammunition’, ‘ambushed’, ‘slamming it down’, ‘public shaming’, and trainees described their sense of injustice at ‘unfair’ feedback. They wanted ‘evidence’, ‘justification’, ‘only what has been witnessed’. The legalistic language suggests a strong desire for justice, and a sense of injustice around previous experiences. Trainees valued ‘mutual respect’ and ‘dialogue’, ‘constructive discussion’ delivered at the right time and right setting for that specific interaction.

The literature highlighted that feedback impacted on trainee satisfaction (Watling et al., 2014), but the interview data suggested that the individual impact of feedback on trainees was far more significant than job satisfaction alone. Trainees described the positive impact of feedback on their personal confidence and sense of belonging, and ‘public shaming’

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experiences that had a marked impact on trainees – with language indicative of psychological trauma. Some trainees experienced heightened stress, anxiety, and would isolate from others. Feedback, and how it reflects the wider culture, impacted on the psychological safety of trainees, which influenced them emotionally and behaviourally. Of concern was the learned behaviour of avoiding asking questions or seeking help, which was recognised as detrimental to patient safety.

Value of feedback

The literature suggests that perceptions of feedback and job satisfaction are closely linked (Cowan 2001), and this is consistent with what participants told us. The literature felt that evidence of the objective impact was lacking (Miller and Archer 2010). Through the interviews, it became apparent that poorly delivered feedback impacted trainees in several ways, impacting their relationships and engagement within departments, affecting training opportunities, and reducing the access to help and support. A reluctance to engage with individuals who had delivered poor feedback could impact on patient safety. Positive feedback made trainees feel engaged, built confidence, and influenced career choices.

Usefulness of feedback

The literature suggested that key factors influencing the credibility, perceived usefulness and weight of feedback given broadly fell into four categories: the participants, content, context, and delivery method. Watling et al. (2014) highlighted that a meaningful relationship and alignment of values between trainer and trainee increased the weight given to feedback. The interview data highlighted that in addition, feedback interactions are an important way of building relationships and generating mutual understanding and respect.

The literature found that the wider culture influences how feedback is both given and received, and placed importance on whether there is a perceived 'learning' culture (Watling 2014; Lörwald, Lahner et al., 2018). Through the interviews, it emerged that trainees placed a high value on feeling like they belonged to the culture, and whether they felt safe within it. Feedback was highlighted as a way that trainees were engaged as part of a department, and was a way that individuals demonstrated interest and investment in the trainees. This helped to build trust. Counter to this, trust was undermined by negative experiences. Departmental gossip was widely felt to be an alternative form of feedback, that undermined

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confidence and trust. This aspect of feedback, and the impact on individuals, was not recognised or discussed in the literature.

Barriers to feedback

The literature highlighted the importance of alignment of motivations of the trainer and the trainee in a feedback encounter (Murdoch-Eaton, 2012; Watling, Driessen et al., 2012). This focused on the drivers for each person arriving at the encounter. Through the interviews it became apparent that alignment and mutual understanding between trainer and trainee are considered very important, and that the trainee wants to feel “understood” and that there is “mutual respect”. Cultural barriers were identified, in particular by trainees with protected characteristics including ethnicity, disability and gender, as a reason that they felt feedback was not relevant or appropriate. In addition, a trainer with a non-UK medical degree expressed the challenge of understanding cultural differences when offering feedback. For both trainers and trainees there was a sense that a difference or separation led to a lack of understanding or difficult exchange of ideas, that there were a set of unwritten implicit norms that had to be understood in order to be “part of the gang”, and to be able to access support and feedback.

Trainers expressed their apprehension at giving challenging or negative feedback, which reflects what we found in the literature (Scarff, Bearman et al., 2019). A range of reasons were given, concern about potential impact for the trainee, concern about the impact on the trainer, and a sense that trainers were unsure of the validity of their observations. A high degree of confidence was required, both on behalf of the feedback giver and of the level of concern, before negative feedback was expressed.

Limitations

Given that this research involves small numbers of trainees and trainers, it is not possible to generalise these findings. However, on discussion with external colleagues in medical training about the findings they are thought to have integrity with the experiences of others. Themes emerging through the interviews did reach saturation after 13 interviews, and we were purposive in our sampling to identify and capture any theoretical gaps in the understanding offered by the literature. We are aware that there will be an element of selection bias as a result of asking for voluntary participation, however we have utilised our

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own networks to minimise the effect of only hearing from trainees who have difficult, but important, stories that they wished to share.

As researchers, we will be unable to view the data with complete detachment from our own experiences and there is a possibility that the data has been interpreted through that lens. This could have been mitigated by involving a non-medically trained individual in the data analysis. However, by the two researchers operating independently and two-point verification of themes and conclusions we have been able to reduce the impact of researcher bias.

The wider picture

Effective feedback is increasingly a focus across a range of organisations and areas. Ossenberg, Henderson and Mitchell (2019) conducted a scoping review of best practice in feedback in 2018, looking at attributes and characteristics of best practice across the health sciences. Key findings of this review were that feedback should be a dialogic process, reciprocal (i.e. two way), desired by the recipient (i.e. requested or invited), responsive, multi-dimensional and future focused (Ossenberg et al., 2019). These findings align with what we heard from trainees – that feedback should be a two-way conversation with mutual investment and respect. The review reflected that while it was clear that a dialogic process with these features was desirable, and frequently discussed, there was little understanding of the drivers and intention behind these priorities, and what is needed to make the feedback ‘partners’ feel engaged. This research has explored some of those themes in more detail and addresses these gaps. In medical training, the GMC has educational policy that speaks to the qualification of the feedback giver and the need for fair and honest feedback as part of medical training (GMC, 2015; GMC 2017). This suggests a ‘sender and receiver’ model of feedback, with a regulatory focus, but doesn’t reflect the more nuanced informal feedback with a dialogic ‘conversational’ approach that trainees’ value.

The Academy of Medical Royal Colleges (AoMRC) published *‘Improving feedback and reflection to improve learning, A practical guide for trainees and trainers’* in 2017, which considers approaches to feedback for workplace-based assessments. The key recommendations include timeliness, frequency of opportunities, and future focus, all of which align with our research. Again, the AoMRC highlight that feedback and reflection

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should be carried out together. The guide emphasises the importance of a positive relationship between trainee and trainer, and that feedback should be a two-way dialogic process. It recommends that cultural differences are recognised and respected in the context of giving and receiving feedback. Our findings align closely with the AoMRC recommendations, which outlines the requirements and expectations of trainers and trainees. Our work adds context to this report and develops the understanding of why this work is particularly important, as well as suggesting some practical next steps that would allow the concepts, increasingly becoming established as accepted needs of the profession, to be translated to meaningful action.

6. Conclusions

This study has shown that appropriate feedback is important to medical training and care delivery due to the following factors.

1. It helps to develop trusting relationships and establish a positive culture. It acts as a starting point for the dialogue between colleagues in the professional setting. Both trainees and trainers have told us that honesty, empathy and integrity are greatly valued.
2. It builds a sense of psychological safety that allows trainees to develop, engage, and promotes patient safety. Poorly delivered feedback impacts on asking for help.
3. It develops clinical performance, confidence in skills and is linked to career choices. Feedback has particularly significant impact early in careers, and helps trainees feel a sense of direction and connection within their teams and their professional work.

What this research told us about the current situation:

1. Useful feedback, delivered by someone who trainees respect, is highly valued. Trainees want guidance and support in being able to work out for themselves how they can improve.
2. Trainees often had vivid recollections of often traumatic negative feedback experiences, many of which were formative events – particularly when earlier in careers. These appear to be prevalent at all stages of training. In more than one case, this led to the individual considering leaving medicine.
3. Feedback that is poorly delivered has a significant detrimental impact on trainee wellbeing, interpersonal relationships, and therefore patient care (through damaging confidence, avoidance that results in missed training opportunities, and fear of asking for help and support). This is a common experience, universal amongst those we spoke to.
4. Trainers that are motivated and deliver fair and well-constructed feedback are highly valued by trainees. However, there is a reluctance to deliver difficult feedback, for fear of repercussions such as being accused of bullying or complaints.
5. An absence of feedback leaves trainees feeling uncertain, insecure, and disconnected. There was a sense that some trainers only offered feedback when something went wrong, that not getting feedback should be interpreted as a sign that you were performing as expected. This did not align with trainees 'need' to know how they fitted in and led to a feeling of insecurity.
6. The impact of culture and belonging were very significant and linked closely to feedback conversations. Trainees felt that feedback conversations were a part of their connection to individuals and departments, and this influenced their sense of community and belonging, their likelihood of pursuing the specialty as a career, and

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their ability to process challenging events. Trainees who had protected characteristics, including female gender, non-White British ethnicity, and disability, reported a sense of cultural disconnection or feeling like an outsider.

7. Gossip within departments, as part of the wider culture, is having a damaging effect on trainees and their relationship with training departments.

7. Recommendations

Feedback is not given and received, but a discussion with aligned expectations, that is experienced with potential learning for all involved. A balanced conversation allows trainees to engage and enables them to determine their own learning and development.

1. Stop referring to 'giving and receiving feedback'. Change accepted narrative to 'feedback conversations'.
 - a. As GMC materials are reviewed and updated, ensure these refer to feedback as a conversation and reflect the need for this to be a dialogic process.
 - i. Materials could include upcoming reviews of *Good medical practice* and *Generic professional capabilities*.
 - b. Through proactive communication of these findings, the GMC to highlight to external stakeholders that feedback should be a two-way developmental conversation and raise awareness that this is the expected standard of feedback.

Building relationships takes time, these relationships are central to developmental feedback – especially for challenging discussions. High turnover clinical placements do not enable these relationships to develop.

2. Promote and support the development of meaningful trainee-trainer relationships.
 - a. Trainees must have a supervisor, there should be continuity of the relationship with a supervisor throughout the duration of a training programme. Trainees and trainers must have adequate protected time to meet at regular intervals, including for more informal discussion. It should not be the case that trainees and trainers meet only to complete summative paperwork.
 - b. Trainee and supervisor relationships should include a mentorship component, with investment from both sides in training and personal development.
 - c. The GMC to work with partners to support trainers to be regularly appraised in their training role, and to seek feedback on their training. Ensure trainees have a voice in this feedback. This could include training bodies within the four nations of the UK, the Royal Colleges and trainer networks.

An absence of feedback is damaging, in particular absence of regular formative feedback.

Feedback is a component of building psychological safety in training settings, embedding inclusive and positive cultures. Trainees who do not feel psychologically safe, or are not part of an inclusive culture, cannot sense check feedback and discuss poorly delivered feedback or negative experiences with a colleague. There is a sense of isolation, felt most acutely by those with protected characteristics. Feedback conversations can be unpredictable, and

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trainers can find the fear of repercussions prohibitive (for trainee and trainer). Embedding feedback as more of a cultural 'norm' may reduce anxiety around this, but unpredictability cannot be eliminated. It is important that individuals who feedback have meaningful training to allow them to do so, and actively develop this skill.

3. The GMC and partners to consider how training in feedback can become 'the norm' for all doctors, integrating an understanding of the impact of feedback, and how to engage in feedback as part of postgraduate medical training.

These skills should be appraised and reflected upon for all doctors, not just trainers. Encourage feedback conversations to become part of daily practice, to enable two-way developmental conversations, decrease power gradient in relationships and to encourage an open culture where all feel safe to be able to initiate a feedback conversation, ask questions, and raise concerns should this be required.

- a. Integrate training on feedback for new doctors (both newly qualified and new to the UK healthcare system), using a range of GMC initiatives, such as Welcome to UK practice. Work with external stakeholders to explore additional opportunities, including employer induction for new doctors and the latter stages of medical school.
 - i. Empower doctors to feel able to request a feedback discussion.
 - ii. Help set realistic expectations for doctors about what feedback should look like and their role as an active participant in it.
 - iii. Ensure that training in feedback acknowledges the wider potential benefits of feedback conversations in terms of a sense of an individual doctor's sense of belonging to a team or department, their psychological safety, and patient outcomes.
- b. Work with partners to develop a 'feedback framework' that supports training and acts as a guide for conversations between feedback participants.
 - i. As the trainer recognition requirements are reviewed, ensure that feedback is appropriately considered, and ensure that they are reflective of developmental feedback conversations.
- c. Use training as an opportunity to emphasise that feedback conversations need to move away from being utilised as a summative tool for assessment, and towards being a tool for development – recognising its far broader role in training, culture, wellbeing, and quality of care.
 - i. Through existing initiatives, such as the Professional Behaviours, Patient Safety (PBPS) programme, highlight the importance of feedback to culture and care quality.
 - ii. Support external partners to ensure appraisal guidance reflects the need for feedback to be a developmental tool rather than punitive.

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- iii. Through ongoing wellbeing work with external partners, highlight the role of feedback.
 - iv. Ensure that the data collected by the GMC through surveys such as the NTS (National Training Survey) adequately capture training experiences regarding training in feedback conversations and feedback experiences. Consider how these impact upon the trainee and their perceptions of the culture of their department.
4. The GMC will commit to align internal GMC feedback practice with the overall principles of these recommendations for the benefit of its employees.

Appendix 1

Title / Author Location	Study design	Participants	Key Conclusions: VALUE	Key conclusions: IMPACT	Key Conclusions: Usefulness of feedback
<p>Alazzawi & Berstock (2019)</p> <p>Use of work-based placed assessments in postgraduate medical education</p> <p>Canada / London</p>	<p>Narrative literature review</p>		<p>Case based discussion - educational value largely user dependent, both the learner and assessor need to undertake formal training on how to use the tool.</p> <p>Challenges - lack of willing assessors / engaged in process</p> <p>Trainee engagement has a significant impact on outcome (Scarff et al., 2019) plus willingness on part of assessor to invest time and effort.</p>		<p>Mohanaruban (2018) survey - 76% of trainees use feedback from CBD to address educational development they require.</p> <p>Discussions often shortened due to time factors - the discussion in the article is primarily around perceived and actual limitations to the effective use of feedback as a tool and possible ways to mitigate these</p> <p>Choice of case - guided by trainee - can skew the usefulness (easy case / good score / tougher assessor etc)</p>

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<p>training - principles and practice. Chapter 4 - Appraisal as part of the training experience: perceptions of trainees (Paice, E).</p> <p>United Kingdom</p>	<p>trainee surveys' 1996, 1999</p>	<p>within North Thames.</p>	<p>difference in perceptions of value between the feedback deliverer and recipient.</p>		<p>not find it useful, were the least satisfied with their posts.</p>
<p>Hauer & Cogan (2012) Realising the potential value of feedback</p> <p>USA</p>	<p>Narrative literature review</p>		<p>Learners may not make a good assessment of what has value to them, or what their learning needs are. Because of a lack of direct, planned observation it is likely that feedback does not align with the trainee experience/what they value. Value of feedback to the trainee is linked to the longitudinal relationship between the trainee and the trainer. Supported participation as a component of clinical duties. Mutual trust. Needs to survive a 'critical</p>		<p>The credibility, or validity of the feedback for learner is augmented task being assessed is meaningful to patient care, and appropriate to the learners graded ability toward independent practice.</p>

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			assessment of its credibility', enhances learning from supervisors. feedback becomes part of the dialogue.		
<p>Kamali & Illing (2018)</p> <p>How can positive and negative trainer feedback in the operating theatre impact a surgical trainee's confidence and wellbeing - a qualitative study</p> <p>United Kingdom</p>	<p>Qualitative study</p>	<p>15 higher general surgery trainees</p>	<p>PF - allowed trainees to relax and enhance operative performance</p> <p>Feedback more valued if it came from a consultant rather than a peer, and respected individuals.</p> <p>Increased self-worth, increased confidence, positive reinforcement, how trainees want to be perceived as trainers themselves, empowerment.</p> <p>Learning - making the learning needs of trainee a priority, enhancement of learning experience, increased willingness to learn and work with that trainer, positive effect on career choices, increased feeling of support.</p> <p>NF - loss of interest, trainee rather not be in theatre, lack of self-worth.</p>	<p>NF impacted on performance in theatre (consider patient safety), and long-term career plans</p> <p>PF impacted on surgical subspecialty chosen</p>	<p>Feedback considered credible when timely, specific, constructive and actionable. More meaningful when source considered credible and when messages align to learners own personal and professional values. Considered to contribute significantly to professional, technical and career development</p>

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<p>Kelly & Richards (2019)</p> <p>Medical education: giving feedback to doctors in training</p> <p>BMJ</p> <p>Ireland/ USA</p>	<p>Practice Update (evidence-based summary)</p>		<p>Formative feedback - valued by doctors in training as relevant due to the proximity and focus on specific, recently performed clinical tasks and behaviours.</p> <p>Consider a learning environment's culture - encourage an interest in receiving feedback, anticipate and prioritise frequent feedback.</p>	<p>Considers the impact of lack of feedback - lack of reinforcement of good performance, poor performance remains uncorrected, learners rely on hearsay, guesswork and trial and error at the expense of patients.</p>	<p>Improves doctors' and students' skillsets and establishes lifelong learning. Most effective when encouraging a learner to assess their own performance / reflection.</p> <p>Consensus and dialogue with trainer.</p> <p>Personal comments counterproductive.</p>
<p>Kluger & Van Dijk (2010)</p> <p>Feedback, the various tasks of the doctor and the feedforward alternative</p>	<p>Narrative literature review</p>		<p>How feedback interacts with your underlying values system and motivations has a significant impact on its value and the value it is assigned by the recipient</p>	<p>Self-regulation theory - interaction between the regulatory focus and the feedback sign in their effect on motivation. Positive feedback increases motivation, and performance under the promotion focus, but debilitate motivation and performance under the prevention focus.</p> <p>in comparison negative feedback - increase performance and motivation</p>	

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Israel				<p>under the prevention focus, debilitate motivation and performance under promotion focus, perception that feedback's impact is related to its perceived future impact on career - in particular negative feedback/feedback intervention is more likely to be damaging if perceived to have high career impact</p>	
<p>Lörwald et al (2018)</p> <p>Factors influencing the educational impact of Mini-CEX and DOPS: a qualitative synthesis</p> <p>Switzerland</p>	<p>Systematic literature review and qualitative synthesis of studies</p>		<p>Found that trainee engagement/participation in the process increased the educational impact of feedback within formative feedback tool use. Found that there was a strong focus in the literature on what the trainees perceived as useful/impactful and that it was far more challenging to comment on objective change in practice/improvement in patient safety</p>	<p>Themes identified influencing educational impact - context , users, implementation and outcome - hierarchical, see diagram.</p> <p>Context - timing</p> <p>Users - training / knowledge and attitude (both trainers and trainee)</p> <p>implementation - observation and feedback, trainee appraisal of feedback.</p> <p>High educational impact of feedback is reported, and this varies on the basis of the setting/environment/context.</p> <p>Overall trainees REPORT a positive</p>	<p>This article highlights that there is a knowledge gap in the literature - is it useful because we think it is useful, or is it useful when we can prove it is useful? The data around the objective impact on performance is lacking - around the impact on culture/motivation</p>

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				impact of getting feedback on their training/performance	
<p>Millar and Archer (2010)</p> <p>Impact of Workplace based assessment on doctor's education and performance: a systematic review</p> <p>United Kingdom</p>	<p>Systematic review</p>		<p>Performance changes more likely to occur when feedback was credible and accurate or when coaching was provided to help subjects identify strengths and weaknesses.</p>		<p>Educational impact of WBPA's - all studies report positive results - but insufficient evidence to show objective improvements in performance. There is limited evidence found for the genuine usefulness of the exercises, but in general the perception of them was positive</p>
<p>Murdoch-Eaton (2012)</p> <p>Feedback: the complexity of self-perception and the transition from 'transmit' to</p>	<p>Commentary</p>		<p>Feedback influences self-perception when learners considered it to be accurate, when they took responsibility for it, and when it was motivating for evaluative judgements (see additional points of interest)</p>	<p>Consider that students might not have accomplished the skills to self-evaluate and self-regulate. In comparison to accomplished practitioners that will self-evaluate and self-regulate, they can judge feedback critically. Need to target these skills in learners.</p>	<p>Considers the concept of variability in an individual's regulatory focus and therefore consequential impact of the type of feedback. Therefore, should be aware of this an alter / use a mix of styles. Not only internally driven motivational changes but also impact of working environment, career trajectory, personal and social</p>

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<p>'received and understood'. United Kingdom</p>					<p>influences. Essentially highlights the need for an individualised approach Consideration of self-regulatory focus will 'enhance the feedback conversation'.</p>
<p>Pelgrim et al (2012) The process of feedback in workplace-based assessment: organisation, delivery, continuity. The Netherlands</p>	<p>Qualitative study</p>	<p>22 postgraduate general practice trainees</p>	<p>Conclusion - deliberate planning of the observation / feedback is essential. Unrealistic assumption that trainees / trainers actively seek out observation encounters.</p>		<p>Feedback needs to be part of an ongoing process, and not an isolated event, and reflect on ongoing learning goals. It relies upon a positive relationship between trainee and trainer</p>

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<p>Saedon, et al (2012)</p> <p>The role of feedback in improving the effectiveness of workplace-based assessments: a systematic review</p> <p>United Kingdom</p>	<p>Systematic review</p>		<p>mini-CEX value as a stimulant for what is perceived to be a useful educational interaction -- positive perception amongst trainees.</p>	<p>Mini-CEX - positive educational impact if written fields utilised. Mini-CEX can facilitate feedback. One study showed frequent use for recommendations for improvement</p> <p>Trust in formative nature of assessments - trainees may feel feedback will have a negative impact on training.</p>	<p>Comments need to be provided and they should be specific, and action based.</p> <p>-sometimes underutilised due to lack of training, time, workload, trust in the formative nature of assessment - such that learners may feel feedback might have a negative impact on training</p>
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<p>Scarff, et al (2019)</p> <p>Trainees' perspectives of assessment messages: a narrative systematic review</p> <p>Australia</p>	<p>Narrative systematic review</p>		<p>1) trainees value developmental assessment measures: real-time, objective, quality of feedback as opposed to mark / score</p> <p>2) trainees become disengaged when assessment messages are not developmental - 'box ticking exercise' etc.</p> <p>3) trainees views depend on the environment, their assessors and themselves</p> <p>Environment -lack of dedicated time, therefore poor qualitative feedback.</p> <p>Assessor - style - style, background, seniority, enthusiasm, engagement.</p> <p>Trainees - level of training, avoiding certain assessors, strategically choosing specific cases; discusses the integrity of this source of assessment for feedback given it is 'in vivo'.</p>		<p>Engagement of both trainer and trainee is a major driver in terms of quality of message received.</p> <p>Assessors engagement can predict a trainee's engagement, and further influence perspectives on the feedback received.</p> <p>Trainees - Learning goal orientated vs performance goal-orientated - trainees will require different types of feedback / level of detail.</p>
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<p>Setna et al (2010)</p> <p>Evaluating the utility of workplace-based assessment tools for specialty training.</p> <p>United Kingdom</p>	<p>Evidence review and narrative synthesis</p>	<p>Obstetrics and Gynaecology</p>	<p>WBPA (OSAT - objective structured assessment of technical skills) perceived benefit of improving technical skills from both trainees and trainers. This article places strong importance on evidencing competence and the value that this should have at the higher level to us as a profession. Suggests that this makes the rest of our training more valuable and robust.</p>	<p>EDUCATIONAL impact - perceived impact from trainees: an opportunity to be observed and receive feedback from experts. Shared info --> enhanced knowledge and skills</p> <p>Assessors report - difficulties in reporting negative feedback via the forms - limiting potential educational impact.</p>	
<p>Watling et al (2012a)</p> <p>Learning from clinical work: the roles of learning cues and credibility judgements</p> <p>Canada</p>	<p>Qualitative study</p>	<p>22 academic doctors (10 male, 12 female) who had been in practice for less than 5 years, range of medical and surgical specialities.</p>	<p>Model of clinical learning- feedback part of a variety of 'learning cues' that facilitate the experience / interpretation / construction of knowledge. Integration of the cue depends on the learner's judgement</p> <p>Cues include feedback, role models, clinical outcomes.</p> <p>Credibility judgement - especially important in feedback - respect in a clinical supervisor increases likelihood</p>	<p>Integration of cue depends on individual interpretation of credibility - learner's values and attitude</p>	<p>Truly influential feedback uncommon</p> <p>Learning path from clinical event, feedback often just confirmed this</p> <p>Debriefing cited as useful - emotional support / maintains confidence / assists in placing negative outcomes / perspective</p>

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			of accepting negative feedback Patient feedback - innately credible		
Watling et al (2012b) Medical Education Understanding responses to feedback: the potential and limitations of regulatory focus theory Canada	Qualitative study	22 academic doctors (10 male, 12 female) who had been in practice for less than 5 years, range of medical and surgical specialities.	Influential feedback can be positive and negative feedback - the way that individuals react to it is highly related to the situation. The value and usefulness of feedback related to the individual's regulatory theory focus.	Kluger & DeNisi - negative impact of feedback on performance - not necessarily if PF or NF. Kluger & van Dijk have developed regulatory focus theory. Promotion vs Prevention focus - interplay of PF and NF on each. Examples in text Perceived impact varied within and across individuals, definite examples where feedback at key points has impacted on the individuals career choices.	Usefulness seems to be related to relevance and appropriateness.

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<p>Watling (2014)</p> <p>Unfulfilled promise, untapped potential: Feedback at the crossroads.</p> <p>Canada</p>	<p>Expert opinion / narrative review</p>		<p>Highlights that feedback is key to development and support, in the context of both positive and negative feedback. Need to consider the learning culture and the learner's response. Individual interpretation of feedback - affected by individual response and learning culture.</p> <p>Conflict of clinical teachers being both feedback providers and assessors. Teacher - learner relationship on shaky ground, highlights frustration and dissatisfaction of trainers perceiving their comments going unheeded; argues that self-appraisal is a damaging/dangerous course of action that may be pursued in the absence of helpful feedback</p>	<p>Will impact differently on everyone - re life experience, preference about feedback style, and emotional response to feedback. Individual make choices about whether feedback merits attention / engage with feedback. (impact of credibility)</p> <p>Meaningful feedback - challenges the learner to reflect and improve, can be difficult in medical learning culture - need long term, trusting relationships (medics rotate). Also, by working in parallel (as opposed to direct observation) feedback culturally undermined.</p>	<p>Feedback considered credible when timely, specific, constructive and actionable. More meaningful when source considered credible and when messages align to learners own personal and professional values. This highlights the importance of the relationship when giving/receiving feedback, and how this is being negatively affected by the frequent change in supervisors within clinical environments/ on rotations.</p>
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Table 1 – details of studies included in the narrative literature synthesis

Abbreviations

PF – Positive feedback; NF – Negative Feedback; MSF – Multi-source feedback; Mini – CEX – clinical evaluation exercise; WBPA – Workplace-based assessments

Appendix 2

Detail of data collection and analysis

Data collection

A semi-structured interview guide was developed through a piloting process, with three participants. As we intended to take an inductive approach, the questions were left as open as practical. Through piloting, we found that the open nature of the questions was useful to allow exploration of a range of themes, and that minimal prompting was required. However, piloting highlighted the need to re-order the interview guide.

With the participants permission, the discussion was recorded by verbatim notes taken during the discussion which were then transcribed and stored on a central secure database. Contemporaneous memos were produced by each researcher but kept private so as not to influence the approach.

Analysis

We adopted a constructivist grounded theory approach to coding, as described by Tie et al (Tie et al, 2019). This involved:

1. Initial coding
2. Intermediate coding (Focused coding)
3. Advanced coding (Theoretical coding)

Initial coding

Both researchers reviewed all the data independently and coded words and phrases that were of importance to the research questions. These were compared to other initially coded data points, and categorised into emerging themes. These themes adapted and developed as data collection continued. We undertook theoretical sampling, and undertook interviews with a diverse range of participants to address gaps in the coded data.

Intermediate coding

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At this stage, coded data points were extracted into a table and grouped with other data points that developed on similar themes. These were then sub-categorised further by both researchers together, and the relationships between the categories mapped and explored. Areas of intersectionality were documented.

Advanced coding

The coded data was reviewed again, and the narrative contained within the data and the relationships between the data points developed. We used a 'storyline' approach to allow integration and cohesive presentation of the data, in a way that maintained integrity and allowed the exploration of meaning. The separate storylines that were developed, such as around the role of relationships and the impact of psychological safety, were woven back together to develop a comprehensive theory.

Appendix 3

Participant key and descriptors

Participant	Gender	Graduate (UK or non-UK medical degree)	Level of training	Formal training role (*).
1	Male	UK	Consultant	Yes
2	Female	UK	Consultant	No
3	Male	UK	Higher trainee	No
4	Female	Non-UK	GP	No
5	Female	Non-UK	Specialty trainee	Yes
6	Female	Non-UK	Foundation trainee	No
7	Male	UK	Speciality trainee	No
8	Female	Non-UK	Foundation trainee	No
9	Male	UK	Specialty trainee	No
10	Female	UK	Specialty trainee	Yes
11	Male	Non-UK	Specialty trainee	Yes
12	Female	UK	Specialty trainee	No
13	Female	Non-UK	Consultant	No

*i.e. college tutor, educational, clinical supervisor or other formally recognised role. Other roles include honorary clinical lecturer, named supervisor for medical students on extended placements such as SSC (special study components).

Appendix 4

Interview guide

We have an hour for this interview, and we may not need all this time. I have 5 questions I would like to ask you, but if thoughts occur to you or if the conversation strays into a different area then this could be something we explore further. In the last 20 minutes, I will make sure that we have covered the key questions – and there will be a timer to let me know that there are only 20 minutes left.

Please ensure all examples you use are anonymous; that they do not identify specific individuals or situations. Also, please note, if you mention anything that could be considered a patient safety issue or concern, I will ask you to clarify it further and will be under obligation to escalate this within the GMC.

If you find anything that we discuss distressing, then please let me know and we will stop the interview.

1) Have you received training in giving or receiving feedback?

If no, would you value training in giving and receiving feedback? (if yes) How could this be most useful to you?

If yes, was this useful? Could you explain why? How could it be better?

2) Tell me about your experience of getting feedback during your training.

Please share examples of a situation where:

- a. you felt feedback was delivered well (nb doesn't need to be positive feedback)
- b. you felt feedback wasn't delivered so well

Minimal prompting from interviewer, only to encourage to consider the situation, delivery, your frame of mind at the time, timeliness, usefulness, relevance, personal characteristics.

3) Tell me about your experience of giving feedback to others.

Again, would you be able to share an example of:

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- a. feedback that you felt was delivered well (nb doesn't need to be positive feedback)
- b. feedback that wasn't delivered so well

What model of feedback have you used? How did you develop your feedback style?

- 4) In your experience, what are the characteristics of useful feedback?** (This may have already been covered in questions 1 and 2 – in which case reflect some of these themes back at the interviewee and ask if they have more to add.

Prompts could include – mode of delivery, how specific / relevant the feedback is, frame of mind at the time, usefulness, timeliness.

- 5) Could you share your thoughts on the impact that feedback has had on you, your career, and your training?**

Do you think this is also reflected amongst your colleagues? Did you ever feel you or other people were treated differently?

Minimal prompting – could you develop on why?

At the end of the interview: I'd like to ask you some questions about yourself. The reason for asking these questions is to see if there are themes that come from our research that might inform us about how experiences differ depending on your background or experiences.

Interviewee code:

What is your current training grade?

Which specialty do you work in?

How would you like your gender recorded?

How do you describe your ethnicity?

Do you have a disability? (Yes / no / prefer not to say)

Where in the UK do you work?

Which country did you attain your primary medical qualification?

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What year did you graduate from medical school?

How many years have you been a consultant? (if relevant)

What is your training grade? (if relevant)

Are you a trainer? Please clarify your trainer role.

Thank you so much for your time!

9. References

Background references

Atewologun, D., Kline, R. and Ochieng, M. (2019) 'Fair to Refer?'

Cantillon, P. (2008) 'Giving feedback in clinical settings'. *British Medical Journal* 337:a1961

Coia, D. and West, M. (2019), 'Caring for doctors, caring for patients', General Medical Council

Kelly, E. and Richards, J. (2019) 'Medical education: giving feedback to doctors in training', *British Medical Journal* 366: l4523

Kluger, A.N. and Van Dijk, D. (2010) 'Feedback, the various tasks of the doctor, and the feedforward alternative'. *Medical Education* 44(12):1166-74. doi:10.1111/j.1365-2923.2010.03849.x. [Accessed 4th September 2020].

Kluger, A.N. and DeNisi, A. (1996) 'The Effects of Feedback Interventions on Performance: A Historical Review, a Meta-Analysis, and a Preliminary Feedback Intervention Theory' *Psychological Bulletin* 119 (2) 254-84

Mohanaruban, A., Flanders L., and Rees H. (2018) 'Case-based discussion: perceptions of feedback'. *Clinical Teacher*. 15(2):126-131. doi: 10.1111/tct.12654. [Accessed 4th September 2020].

Van der Ridder, J.M.M., Stokking, K.M., McGaghie, W.C., and ten Cate, O.T.J. (2008) 'What is feedback in clinical education?' *Medical Education*: 42: 189–197 doi:10.1111/j.1365-2923.2007.02973.x [Accessed 4th September 2020].

Literature review references

Alazzawi, S. and Berstock, J. (2019). 'Use of work-based assessments in postgraduate medical education'. *British Journal of Hospital Medicine* **80**(5): 285-287.

Castanelli, D., Jowsey, J., Chen, Y. and Weller, J. (2016). 'Perceptions of purpose, value, and process of the mini-Clinical Evaluation Exercise in anesthesia training.' *Canadian Journal of Anesthesia* **63**(12): 1345-1356.

Good conversations, fairer feedback

Cowan, G. E. (2001). 'Assessment and appraisal of doctors in training : principles and practice', Royal College of Physicians of London.

Hauer, K. E. and J. R. Kogan (2012). 'Realising the potential value of feedback.' *Medical Education* **46**(2): 140-142.

Kamali, D. and Illing, J. (2018). 'How can positive and negative trainer feedback in the operating theatre impact a surgical trainee's confidence and well-being: a qualitative study in the north of England.' *BMJ Open* **8**(2): e017935.

Kelly, E. and Richards, J. (2019). "Medical education: giving feedback to doctors in training." *British Medical Journal* **366**: l4523.

Lörwald, A., Lahner, F., Greif, R. et al. (2018). 'Factors influencing the educational impact of Mini-CEX and DOPS: A qualitative synthesis.' *Medical Teacher* **40**(4): 414-420.

Miller, A. and Archer, J. (2010). 'Impact of workplace-based assessment on doctors' education and performance: a systematic review.' *British Medical Journal* **341**: c5064.

Murdoch-Eaton, D. (2012). 'Feedback: the complexity of self-perception and the transition from 'transmit' to 'received and understood' *Medical Education* **46**(6): 538-540.

Pelgrim, E., Kramer, A., Mokkink, H. and van der Vleuten, C. (2012). 'The process of feedback in workplace-based assessment: organisation, delivery, continuity' *Medical Education* **46**(6): 604-612.

Saedon, H., Salleh, S., Balakrishnan, A. et al. (2012). 'The role of feedback in improving the effectiveness of workplace-based assessments: a systematic review.' *BMC Medical Education* **12**: 25.

Scarff, C., Bearman, M., Chiavaroli, N. and Trumble, S. (2019). 'Trainees' perspectives of assessment messages: a narrative systematic review.' *Medical Education* **53**(3): 221-233.

Setna, Z., Jha, V., Boursicot, K. and Roberts, T. (2010). 'Evaluating the utility of workplace-based assessment tools for speciality training.' *Best Practice and Research Clinical Obstetrics and Gynaecology* **24**(6): 767-782.

Watling, C. (2014). 'Unfulfilled promise, untapped potential: feedback at the crossroads.' *Medical Teacher* **36**(8): 692-697.

Watling, C., Driessen, E., van der Vleuten, C and Lingard, L (2012)a. 'Learning from clinical work: the roles of learning cues and credibility judgements.' *Medical Education* **46**(2): 192-200.

Good conversations, fairer feedback

Watling, C., Driessen, E., van der Vleuten, C., et al. (2012)b. "Understanding responses to feedback: the potential and limitations of regulatory focus theory." *Medical Education* **46**(6): 593-603.

Watling, C. J. (2014). 'Unfulfilled promise, untapped potential: feedback at the crossroads.' *Medical Teacher* **36**(8): 692-697.

Qualitative methods references

Chun Tie, Y., Birks, M., and Francis, K., (2019) 'Grounded theory research: A design framework for novice researchers', *SAGE Open Medicine*. 7: 2050312118822927.

General Medical Council (2019) 'The State of Medical Education and Practice in the UK. The workforce report' https://www.gmc-uk.org/-/media/documents/the-state-of-medical-education-and-practice-in-the-uk---workforce-report_pdf-80449007.pdf [accessed 17th September 2020].

General Medical Council (2020) 'Quality assurance and research ethics'. <https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research/a-guide-to-our-research/quality-assurance-and-research-ethics>. [accessed 10th August 2020].

Hammarberg, K., Kirkman, M., de Lacey, S., (2016), 'Qualitative research methods: when to use them and how to judge them', *Human Reproduction* **31**(3): 494

Kitto, S., Chesters, J., and Grbich, C. (2008). "Quality in qualitative research", *Medical Journal of Australia* **188** (4): 243-246.

NHS Health Research Authority (2020) <http://www.hra-decisiontools.org.uk/ethics/> [accessed 10th August 2020]

Oxford University Press (2020) Oxford English Dictionary. <https://www.oed.com/> [accessed 4th September 2020]

Other resources used:

Paley, J., and Lilford, R., (2011), 'Qualitative methods: an alternative view', *British Medical Journal* **342**(424)

Teherani, A., Martimianakis, T., Stenfors-Hayes, T., et al. (2015), 'Choosing a Qualitative Research Approach', *Journal of Graduate Medical Education*. **7**(4): 669–670

Good conversations, fairer feedback

Wider picture references

Ossenberg, C., Henderson, A., Mitchell, M., (2019), 'What attributes guide best practice for effective feedback? A scoping review'. *Advances in Health Sciences Education*, 24:383–401

Academy of Medical Royal Colleges, (2017), 'Improving feedback and reflection to improve learning. A practical guide for trainees and trainers' https://www.aomrc.org.uk/wp-content/uploads/2017/06/Improving_Feedback_0517-2.pdf [Accessed 14th August 2020]

General Medical Council (2015) 'Promoting excellence: standards for medical education and training' <https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/promoting-excellence> [Accessed 14th August 2020]

General Medical Council (2017) 'Generic Professional Capabilities Framework' https://www.gmc-uk.org/-/media/documents/generic-professional-capabilities-framework--0817_pdf-70417127.pdf [Accessed 14th August 2020]

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