detailed, specific and descriptive comments on the form to guide their discussions. We have produced versions of the guide that offer space for recording comments within the structured sections of the guides (*see* Appendix 2). This encourages observers to consider where in a consultation the interviewer is at any one time and where he or she should be aiming for. The guides are a tool for self- and peer assessment and can provide a record of others' comments for the learner to take away.

2 **The use of the guides as a method of summarising the session**
A second effective use of the guides is as an aid to summarising and recording the learning that has occurred by the end of a session so that learners can conceptualise their learning more precisely. This is an important final step in agenda-led outcome-based analysis. The facilitator (or another group member) can reiterate the skills that have been discussed and explain how they fit into the structure of the consultation. She can provide an overview of what has and hasn't been covered in the particular consultation or teaching session. Learners can later use the guides as an *aide-mémoire* in the consulting room or at the bedside to allow them to practise the skills that have been identified. To this end, we have developed a laminated pocket-card version of the guides that learners (and clinical faculty) can easily carry with them. The facilitator can start the next session by enquiring how the participants have progressed with these skills since they last met.

Here then is a way of structuring learning over time that makes maximum use of the experiential methods which are so essential to communication skills programmes. As we shall see in Chapter 9, communication courses need to be designed in a 'helical' fashion – 'one-off' courses are of little value. The communication curriculum needs to run throughout medical education as a whole, with built-in repetition, refinement and increasing complexity. The guides offer a way of piecing together the skills that occur randomly throughout this helical curriculum so that they are used to their greatest advantage. Because the guides are so central to our approach, we take a closer look in Chapter 10 at how to use and adapt them for learners at different levels of medical education.

Phrasing feedback effectively in communication skills teaching sessions

A key element of agenda-led outcome-based analysis as outlined above is the use of descriptive feedback. Here we continue our examination of strategies for analysing communication skills and giving feedback by exploring descriptive feedback in depth. Agenda-led outcome-based analysis provides an overall framework for organising communication skills teaching while descriptive feedback specifies how to phrase feedback within that framework to ensure non-judgemental and specific comments.

Learners in medicine may rarely have experienced a learning situation involving observation where they felt supported by a well-motivated teacher who was able to give non-judgemental yet constructive criticism (Ende *et al.* 1983; McKegney 1989; Westberg and Jason 1993). What guidelines can we advocate to both facilitators and group members at all levels of medical education to

promote the phrasing of honest yet non-destructive feedback that the receiver can comfortably take on board?

Feedback, like other communication, is most effective when it is an interactive process and not just the one-way delivery of a lecture telling someone how you think they did or what to do differently. Just as in the doctor–patient interview, the interactive 'frisbee' approach rather than the shot-put approach is required to enable communication in the teaching and learning arena to be successful (Barbour 2000). However well conceived and well delivered your feedback message may be, you will not achieve mutually understood common ground and confirmation of the other person if all you do is heave the message out there and walk away. Interaction, collaboration and mutual discussion of all the messages travelling both ways are required to enable the learner to hear, assimilate and potentially act on feedback.

Principles of constructive feedback

The following principles of constructive feedback are by no means new. They have been available for over a quarter of a century (Gibb 1961; Johnson 1972; Riccardi and Kurtz 1983; Silverman *et al.* 1997) yet they have not infiltrated medical education to an appreciable extent. Even in communication skills teaching, an understanding of the principles of feedback is by no means universal.

Feedback should be descriptive rather than judgemental or evaluative

Avoid phrasing feedback in terms of good or bad, or right or wrong. Terms such as 'awful', 'stupid', 'brilliant', 'lazy' and 'wonderful' are of little value to the learner. Negative evaluation such as:

> *'The beginning was awful, you just seemed to ignore her.'*

is bound to generate defensiveness. A judgement has been made which implies that the observer is comparing the person performing the interview with a set standard against which the person has failed. Contrast this with:

> *'At the beginning of the interview, I noticed that you were facing in the opposite direction looking at your notes which prevented eye contact between you.'*

This is descriptive, non-judgemental feedback linked to outcome which is much easier to assimilate as a learner. It still points out the problem but in a way that is not seen as some deficiency of the learner. Similarly, positive evaluation is also unhelpful when provided judgementally:

> *'The beginning was excellent, great stuff.'*

This does little to convey why something was good and again it implies a standard that has already been agreed. Contrast it with:

> *'At the beginning, you gave her your full attention and never lost eye contact – your facial expression registered your interest in what she was saying.'*

Communication skills are intrinsically neither good nor bad – they are simply helpful or not helpful in achieving a particular objective in a given situation. Because descriptive feedback is such a key component of constructive criticism, we elaborate on it in greater detail later in this chapter.

Make feedback specific rather than general

General or vague comments such as:

> *'You didn't seem to be very empathic'*

are not very helpful. Feedback should be detailed and specific. Focus on concrete descriptions of specific behaviour that you can see and hear. Vague generalisations do not allow an entry point to looking at possible changes that might help the situation and may well only produce the reply *'Oh yes I was!'*. Contrast:

> *'Looking from the outside, I couldn't tell what you felt when she told you about her unhappiness. Your facial expression didn't change from when you were concentrating on her story – I felt she might not have known if you empathised with her.'*

This leads constructively into looking at both the overall concept of empathy and the specific skills that allow patients to appreciate empathy overtly.

Use the first person singular when giving feedback: *'I think . . .'* rather than *'We think . . .'* or *'Most people think . . .'*. Focus on your personal viewpoint and this particular situation rather than on situations in general.

Focus feedback on behaviour rather than on personality

Describing someone as a *'loudmouth'* is a comment on an individual's personality – what you think he *is*. Saying *'You seemed to talk quite a lot – the patient tried to interrupt but couldn't quite get into the conversation'* is a comment on behaviour – what you think an individual *did*. Behaviour is easy to alter, personality less so – we are more likely to think that we can change what we 'do' than what we 'are'.

Feedback should be for the learner's benefit

Patronising, mocking, superior comments tend to benefit the observer rather than help and encourage the learner. Feedback should be given that serves the needs of the learner rather than the needs of the giver. It should not be simply a method

of providing 'release' for the giver. Giving feedback that makes us feel better or gives us a psychological advantage serves only to be destructive to the learner and ultimately to the group as a whole.

Focus feedback on sharing information rather than giving advice

By sharing information, we leave the recipients of feedback free to decide for themselves what is the most appropriate course of action. In contrast, when we give advice, we often tell others what to do and take away their freedom to decide for themselves – we inadvertently put them down. In working with learners there is clearly a fine line between sharing information and giving advice but we should move away from advice giving as a primary form of feedback towards the concept of generating alternatives and making offers and suggestions.

Check out interpretations of feedback

Givers of feedback should take responsibility to check out the consequences of their feedback. Just as in the consultation, it is important to be very conscious of the recipient's verbal and non-verbal reactions and overtly check out their response. We should be highly aware of the consequences of our feedback.

In turn, the recipient should check whether he has understood the feedback correctly: *'What I think you mean is . . .'*. This prevents distortion and misunderstanding, which so easily occur if there is even a hint of defensiveness.

Lastly, it is helpful for both the giver and the recipient of feedback to check whether others in the group share their impressions.

Limit feedback to the amount of information that the recipient can use rather than the amount we would like to give

Overloading a person with feedback reduces the possibility that he will use any of it effectively. Again we may be satisfying some need of our own rather than helping the learner. We may feel that we have failed if we do not cover everything that we have seen rather than just concentrating for now on the most relevant areas for the learner. We must learn to trust that other opportunities to return to missed areas will arise later in the course – what is the point of covering everything now if it is not taken in by the learner?

Feedback should be solicited rather than imposed

Feedback is most usefully heard when the recipient has actively sought it and has asked for help with specific questions. We have already covered the importance of this concept when we discussed agenda-led analysis of the consultation. It is important for the group to have agreed in advance how and when feedback is to be given and received.

Give feedback only about something that can be changed

There is little point in reminding someone of a 'shortcoming' that they cannot easily remedy. A nervous mannerism or a stutter may be a problem that can be acknowledged sensitively but detailed feedback about the mannerism itself may be unhelpful:

> *'If you didn't stutter so much, the patient would be able to understand you so much better – it's painfully slow for the patient.'*

More useful would be:

> *'Obviously the stutter is something you've had to live with over the years. Is there anything you'd like help with from the group with that or is it something you'd like us to accept and work around?'*

Similarly, an organisational problem such as constant telephone interruptions might be more difficult to change if the learner is a resident or student rather than the doctor in charge of the unit. Working on how to deal with interruptions rather than how to prevent them might be of more value to learners in these situations.

Descriptive feedback

How do we encourage learners to give appropriate feedback that conforms to the principles outlined above and that will positively enhance learning? The answer is to use descriptive feedback, a simple and easily understood approach which naturally allows feedback to be:

- non-judgemental
- specific
- directed towards behaviour rather than personality
- well intentioned
- shared
- checked with the recipient.

Descriptive feedback is the process of holding a mirror up for the group. Instead of *'what was done well'* and *'what could have been done differently'*, we substitute:

- *'Here's what I saw or heard'*
- *'What do you think?'*

By describing exactly what you saw in the interview, you will almost always produce non-evaluative specific feedback. An example is required here to demonstrate the power of the method. If a patient starts to look down, fiddles with her fingers, slows down her speech and looks weepy, and the interviewer then asks her how her family is getting on to which she responds that she is fine, regains her equanimity and never returns to why she looked so uncomfortable, you could give feedback in two different ways:

> *'I think you really missed a big cue when she obviously had something important to say and you chickened out of asking her.'*

This is judgemental, general feedback that assumes a motive for the learner's actions with an implied comment on his personality.

Contrast this with:

> *'At 3 minutes 23 seconds, there was an interesting point when she starts to look down, fiddles with her fingers, slows down her speech and looks weepy. You then asked her about her family and she didn't ever seem to get back to what was upsetting her – what do you think, John?'*
>
> *'Yes, I didn't know quite how to get her to open up.'*

This is descriptive feedback that is non-judgemental and very specific. It also very effectively leads the discussion on to what outcome the learner is trying to achieve. If the learner in fact did not wish to enter the realm of the patient's feelings because he was an hour behind, then what he did achieved his ends. He can own the thoughts and feelings that were contributing to his actions. However, even then the group could practise at this point how they might get the patient to open up if they had enough time on another occasion or they could consider alternatives that take the patient's point of view into account.

Notice how descriptive feedback concentrates initially on *what, when, where* and *how* rather than *why*. Comments on *why* something was done move from the observable to the inferred and can easily lead into the more contentious territory of assumptions about motives and actions (Premi 1991).

Here are some more examples. Note that *positive* feedback also benefits from description that is concrete and specific.

Compare:

> *'I think you were great the way you got the patient to tell his story so easily'* (general, evaluative, and not very helpful in learning)

with

> *'You asked her when it started and then let her talk – whenever she seemed to stop, you waited quite a few seconds and said ''uh-huh'' and she continued her tale – she told you all about her problem and her fears in her own words'*

or:

> *'That was awful, you just lectured her'*

with

'When you explained the condition to her, you gave her a lot of information and talked in some detail for two minutes without pause. She didn't ask any questions but I noticed that she frowned after about 40 seconds. What do you think, John?'

Note how well descriptive feedback fits in with the principles of agenda-led outcome-based analysis. First, reflection back to the learner who is being observed encourages self-problem solving. Secondly, description of what happened leads on directly to what effect it seemed to have. This in turn leads on to what the learner wished had happened and what *outcome* the learner or the patient would like to have achieved. Finally learners can consider what skills would be helpful in enabling them to get there.

The aims of descriptive feedback are to:

- reduce defensiveness
- promote open discussion
- increase experimentation
- aid the presentation and consideration of available alternatives
- ultimately facilitate change in behaviour.

By trying to be more descriptive, we are attempting to create a non-judgemental climate that encourages learning. Of course, some judgement is involved in the very act of selecting what area to describe – there is a selective perceptual bias in all that we do. But by moving our language away from the judgemental framework of good and bad and into the descriptive framework of 'what we saw', we change the way that feedback is received and possibly even the way that we think. If the observer has formed a judgement, she should hold back from using evaluative language so that the receiver of feedback can make use of the descriptive information himself without becoming defensive. This is not to say that analysis and interpretation should never feature but that the person conducting the interview should be given every opportunity to make inferences himself first. If this is not fruitful, then it may be appropriate to move into a slightly more interpretative mode.

Here is an example of this graded approach:

Jane:	*'You asked four questions in quick succession and the patient just answered yes or no.'*
Facilitator:	*'What do you think John?'*

If John answers *'I think that I got some useful information with those questions'* rather than *'Yes I felt it was very hard going'*, you could proceed as follows:

Facilitator:	*'Can I just return to what you were saying, Jane? What were you thinking about John's questions? What effect did you think they had?'*
Jane:	*'I think John's closed questions led the patient just to give answers rather than tell his story.'*

Note that in the above example, Jane has still used non-judgemental language without reference to good or bad but has moved slightly along the path of analysis by inferring cause and effect.