POTENTIAL PATTERN

▲ Standardized Patient Feedback: Making It Work Across Disciplines

Linda Dayer Berenson, PhD, CRNP, RN
Sharon W. Goodill, PhD
Sarah Wenger, PT, DPT, OCS

In health professions education, feedback can be defined as the sharing of information about a student's performance. The most valuable learning occurs when students receive detailed feedback delivered in a way they can utilize it. In clinical simulations, feedback from a standardized patient (SP) offers a unique perspective. This article presents some of the underlying theory and research on feedback delivery with a particular emphasis on the role of nonverbal communication. We explore what feedback students need from SPs, how to provide feedback effectively as well as common challenges to the process. The authors, working from different health care disciplines, collaborated to develop a training workshop for the college's SPs designed to ensure a consistent approach to SP feedback delivery. We describe this workshop and its outcomes. J Allied Health 2012; 41(1):e27–e31.

Feedback Theory

STUDENTS need feedback so that they can gain knowledge of their performance and make modifications based on that knowledge.[2] Feedback allows us to determine what the student has gained from the experience as well as what he or she may be assuming about the activity or its outcome.[1] Without feedback, the student may develop a false sense of his or her performance. It has been reported that effective feedback resulted in up to 70% of the medical students studied recalling at least one positive change they made in their clinical practice and attributing that change to the feedback they had received.[3] Other students reported that positive feedback validated their clinical practice and this is also beneficial.[3]

Dr. Dayer Berenson is Assistant Clinical Professor of Nursing, **Dr. Wenger** is Assistant Clinical Instructor of Physical Therapy, and **Dr. Goodill** is Clinical Professor and Chairperson, Department of Creative Arts Therapies, at Drexel University College of Nursing and Health Professions, Philadelphia, Pennsylvania.

PP1037 – Received Oct 20, 2010; accepted Oct 3, 2011.

Address correspondence to: Dr. Linda Dayer Berenson, Drexel University College of Nursing and Health Professions, 245 N. 15th St., Mail Stop 501, Bellet Building, 7th Floor, Philadelphia, PA 19102, USA. Tel 215-762-4475, fax 215-762-1259. lad56@drexel.edu.

Journal of Allied Health Online (1945-404X)

Positive feedback serves to sustain behavior that is appropriate and effective, while corrective feedback identifies behaviors that are inappropriate, ineffective or unsafe. Students need a mixture of positive and corrective feedback to successfully improve their performance including WHAT behaviors and critical thinking processes need to change and HOW to make these changes.[1,3] A constructive discussion that explores clinical reasoning and alternative actions is imperative for student learning.[4] The process of feedback should be collaborative with both the SP evaluator and the student sharing their thoughts about the student's performance and contributing their ideas about how performance could improve.[3]

Feedback from an expert such as a professor or clinical instructor provides a student with information about his or her clinical decision making, interaction skills and other performance measures. In contrast, feedback from an SP provides the student with powerful and undeniable information about the impression he or she left with that individual.[4] SPs can provide students with unique and valuable information about how their actions and behaviors affected the SP's emotional experience of the student, the SP's trust in the student, and the SP's understanding of information exchanged. Thus the SP's feedback fills a critical educational role in the interpersonal and affective domains.

Nonverbal Communication In the Feedback Process

British essayist and playwright George Bernard Shaw is credited with this truism: "The single biggest problem in communication is the illusion that it has taken place."[5] Nonverbal communication can be described as the unspoken elements of human interaction. These elements include but are not limited to features of the physical environment, facial expressions, posture, gesture, interpersonal space, vocal characteristics, touch, and shared behaviors. Participants in conversations take turns when speaking, but the nonverbal communication (NVC) is constant, reciprocal and simultaneous. We "dance" together all the time, following a choreography learned through social norms and shaped by our physical characteristics, the structure of our language, our intent and our personality. Despite the fact that over 60% of meaning and information is conveyed through nonverbal communi-

cation,[6] most health care training emphasizes the verbal components. Nonverbal communication can impact how content is understood and retained,[6] and can influence the value a student places on the feedback session. This discussion will focus on four aspects of NVC: individual nonverbal style, verbal/nonverbal congruence, shared behaviors, and interpersonal space.

INDIVIDUAL NONVERBAL STYLE

In the simulated clinical encounter, the SP embodies the patient role using information from case training and previous experience. The SP uses specific physical movement patterns and nonverbal emotional and relational cues to convey the patient character. We recommend that in the interim between encounter and feedback session, the SP deliberately comes out of the patient character and transitions back to the natural self. To do this one can literally and physically "shake off" the patient. This way, when the SP and the student sit down for the feedback session, the nonverbal information reinforces the shift in roles. During the encounter, the student is responsible for initiating the behaviors that build rapport. In the feedback session, it is the SP who is responsible for engendering rapport and a sense of psychological safety for the student. Thus, the SP needs to consciously engage in the nonverbal elements of building that relationship.

VERBAL/NONVERBAL CONGRUENCE

Discrepancies between information content and emotional tone in verbal and nonverbal communications are common. For example, one can convey warmth and respect while delivering unwelcome news or incongruence can be used for humor. However, discrepant verbal and nonverbal messages can create uncertainty and unless there is shared understanding the response can be one of displeasure or withdrawal.[7] For example, if the SP gives verbal corrective feedback to the student and simultaneously averts his or her gaze, the student is left to wonder about the authenticity of the feedback, or if there is something unsaid yet important that is behind it. If the SP says, "I thought you did a great job with this assessment" through tight, pursed lips, the student will pick up on the discrepancy and prepare for the bad news that is sure to come. Alternatively, the SP could say, "I felt you did some wonderful things in this assessment, and there are also some things to work on in the future" and the student will generally perceive the SP's honesty in communicating the reality and duality of his or her impressions.

SHARED BEHAVIORS

Research has shown that posture sharing—when two people in a conversation configure their bodies in similar positions—is associated with positive feelings about one's self and the other participant in the conversation. These positive feelings create rapport and a sense of affiliation.[2,8] We also know that that during verbal exchange, people engage in both interactional synchrony and echoing at the physical level. The term interactional synchrony refers to "the ongoing co-occurrence of change in movement and speech".[7] Echoing is like synchrony, but there is a very brief delay, so that one person appears to follow the other in the use of a gesture, a postural shift, or a change in the dynamics or rhythm of a movement.[9] In a study of medical residents and their patients, Fraenkel discovered that truly synchronous moments occurred spontaneously and were associated with better patient retention of the information exchanged at that time.[9] In another study, of friendship dyads and counseling dyads in verbal discussion, Fraenkel identified that echoing was associated with the process of building rapport.[10] Others observed the same phenomenon while studying the emerging relationship between a medical acupuncturist and her patients.[11,12] As the relationship developed, a pattern shift occurred. In the beginning, "doctor echoes (or follows) the patient" more frequently, working as skilled clinicians do, to communicate their full attention and interest in the patient to establish rapport. Over the 12 weeks of the study, the patient would increasingly echo or follow the doctor, and this pattern was congruent with the patients' descriptions of their warm and trusting feelings towards the doctor and her treatment of them.

Neuroscience research has identified "mirror neurons" in humans and other mammals.[13] These fibers are activated when we observe others moving, and activated as though we ourselves were moving with those observed. This kind of "matching" at the level of the central nervous system has been discussed as the neurophysiological basis for empathy.[14] This evidence supports early theory that empathy is essentially a kind of physiological matching in which we naturally join with others and thus are able to "feel into" or empathize with their experience.[14]

Applying this body of research evidence to SP/student feedback sessions, we recommend that the feedback portion of a simulation be video recorded. This way SPs can review their work with the student, watching for sequences of shared behavior and reflecting on how to build rapport and affiliation during the discussion. A Standardized Patient should look for subtle nonverbal cues from the student to activate his or her own empathy process and sensitivity to the student's vulnerability as a learner.

INTERPERSONAL SPACE

The spatial dimension of NVC is the focus of research known as proxemics. Knapp and Hall identified four zones of interpersonal proximity, linking each to norms for different kinds of interactions and relationships.[7] In the academic setting, feedback for a student is most often framed in the "casual-personal space" zone range of 18 inches to 4 feet. The "social-consultative" range of 4 -12 feet is too impersonal for two participants who are focusing on each other for the exchange of important information. The "intimate space", which ranges from physical contact to 1.5 feet, occurs often during physical exams in health care encounters. In switching to the feedback session, when both student and SP tran-

sition to new roles and a discussion mode, the intimate space proximity is inappropriate. Trainers and SPs should keep in mind that social norms for interpersonal distance are highly culturally inflected. Thus, when the SP/student dyad is intercultural, participants in the interaction may experience comfort and discomfort at different degrees of physical closeness.[15] It helps to have some knowledge of cultural norms for touch, eye contact, and interpersonal distance, but to present that information here is beyond the scope of this paper. A good guideline is to simply pay attention to the comfort level of the other person.

By attending to these aspects of the nonverbal dimension in feedback sessions, SPs can learn to more effectively build rapport and convey salient information. In this way, George Bernard Shaw's observation can be rendered more of a cautionary note and less of an inevitability, at least regarding the delivery of feedback to students in simulated clinical learning environments.

Guidelines For SP Feedback Sessions

STRUCTURE OF THE SP FEEDBACK SESSION

We use a structured and interactive approach to feedback delivery. This supports the development of a dialogue between the student and the SP evaluator. It includes the student's self-assessment and, since it is collaborative, helps the student take responsibility for his or her own learning.

Framing the feedback session requires some thought. Optimally there will be enough time for the feedback to be provided immediately after the learning activity. This helps to ensure that the events are fresh and clear in both the student's and the SP's minds. Feedback should be given in a psychologically safe environment.[16] For many health professions students, this will be the first time they receive feedback from the patient's perspective, and this could be stressful and overwhelming. The need for student involvement in the feedback process is based on the Confucian belief of, "Tell me, and I will forget. Show me, and I may remember. Involve me, and I will understand".

Planning for consistent SP feedback delivery is time well spent. Good planning and training will ensure your students receive effective feedback that will result in positive learner outcomes.[17] In addition to SP feedback, the overall plan can include peer feedback from other students, self-evaluation, and faculty/expert evaluation. This multisource approach to feedback can be applied in a variety of combinations and sequences. The substantial literature on multisource or 360-degree feedback is beyond the scope of this article but recommended to those building feedback programs.[3]

TIMELINE FOR THE FEEDBACK SESSION

Branch and Paranjape used a five-to seven-minute feedback session and identified three general categories of feedback: Brief (<5 minutes), Formal (5-20 minutes), and Major (15-30 minutes).[2] Our SPs are trained to work in the Formal feedback time frame, with an opening phase of 1-2 minutes; a discussion phase of 3-5 minutes and a summary phase of 1-2 minutes (total time 5-10 minutes). Brief feedback will have a very limited focus, formal feedback will focus on two or three key points while major feedback may be necessary to address problematic or more complex student cases.[2,16] A formal feedback session is interactive through the use of open-ended questions.[2]

Opening Phase. The SP opens by letting the student know what to expect during the feedback session and asking the student whether he or she is open to receiving feedback. The SP then invites the student to share his or her own impressions and self-evaluation. The consensus from the literature is that SP observations on the student's performance should begin with a positive comment.[16] This can serve as a transition from the opening phase into the discussion.

Discussion Phase. The discussion should last 3-5 minutes. If additional time is available, this is the phase to be expanded. The SP needs to focus the discussion phase to ensure the most salient points are given ample attention. It is important not to overload a student with too much information. The feedback needs to be non-judgmental and specific enough that the student understands which behaviors should be continued and which should be modified.[1]

Feedback is most meaningful when it is based on solid, observable data.[16] General positive comments such as "You're doing a great job" may be pleasant to give, but do little in terms of teaching. Rather, positive feedback should recall specific examples from the encounter, such as, "You did a great job asking me follow-up questions, keep it up." Specificity is vital when delivering corrective feedback. It is difficult for students to receive and apply global critique. For example, a statement like "You seemed unsure of yourself" implies a problem with self-confidence, but leaves the student with no clear ideas for improvement. Instead, the SP could say "I saw you hesitating before moving onto the next step in the exam. You said 'um' a lot then, and you were not looking directly at me." With this feedback, the student can identify the verbal and nonverbal behaviors he or she needs to address and can start to make changes.

Following this, the discussion should then focus on the impact of the behavior. The SP should state how the behavior made him or her feel in the patient role, and focus on describing the influence on the interpersonal experience. The SP should not prescribe corrections but instead can engage the student in collaborative problem-solving by posing open-ended questions like, "How might you have done this differently?"[2]

The last part of the discussion focuses on the future and begins the transition to the summary phase.

Summary Phase. The feedback session ends with the summary phase, which should last approximately one minute. This is the time to reinforce important points that occurred during the earlier phases, and confirm that the student understands those points. Students should leave a feedback session with a few specific goals and ideas for improving future performance.

TABLE 1. Do's and Don'ts for Effective SP Feedback Delivery

Do's

- Set a tone that focuses on improvement.
- Utilize open-ended questions.
- Acknowledge and explore emotional responses.
- Use active listening skills.
- Respond to both verbal and nonverbal communication cues.
- Use empathy.
- Involve the student in plans for future improvement.
- If offering an alternative, always speak from the patient role.
- Verify understanding of the content by the student.

Don'ts

- Don't ignore emotional responses from the student.
- Don't comment on personal attributes that cannot be changed.
- Don't use the term 'negative feedback'.
- Don't provide false praise.
- Don't use a judgmental approach.
- Don't be vague or use global statements.

Overcoming Barriers to Giving Effective Feedback

It is important to discuss some of the barriers to the process of effective feedback. The most obvious of these barriers is time.[2] Since feedback requires individual meetings, if there are large numbers of students, this can become an overwhelming task. It is important to have buy-in from students, faculty and administration to create a sense of value in this investment of time.

Other barriers reside not at a systems level, but at the individual level. Giving feedback, especially corrective feedback, can be uncomfortable. Many evaluators fear that corrective feedback will undermine a student's confidence or will be met with a strong emotional response.[17] It is important for SP evaluators and students alike to recognize that they will need to tolerate a certain level of discomfort throughout the feedback process.

We want to foster confidence in our students, and for students to become comfortable in their knowledge, education, and clinical reasoning. Providing individualized feedback that helps them develop in these areas will be good for their confidence, not detrimental to it. It is important for students to understand how their behavior is affecting quality of care. Students who perform poorly because they lack knowledge or have poor decision-making skills need to recognize their problems and work on them. Feedback provides them with the tools to make these corrections. Students who have appropriate knowledge and decision-making skills, but who perform poorly because they get nervous, also need to understand how quality of care is affected. They need to gain an appreciation of what they have learned and mastered. When students employ accurate knowledge of performance to improve the quality of their work they can gain confidence for two reasons. First, they become confident that their perceptions of performance are accurate. Second, they become confident in their ability to make improvements in their performance. Gaining this sense of control over both self-perception and performance improvement will help students feel more comfortable with their knowledge, skills and decision making.

Sometimes students can have a strong emotional response during feedback sessions. Students may disagree with the evaluator; they may become upset and sometimes cry. While it is important for SP evaluators to gauge what feedback a student can manage, it is imperative that SPs do not withhold feedback to avoid emotional responses. This is counterproductive to the student's learning and is contrary to good teaching principles. It is important for SPs and students to understand that feedback is an investment in the student's development. Constructive feedback is a caring gesture and should be presented to the student in this light. When students perceive feedback as caring and understand the investment the SP is making in their learning, they may be less likely to have strong emotional responses and are more likely to be open to the feedback.

SP Feedback Training Workshop

According to Lockyear,[3] when SPs are competently trained, students are more likely to accept, value and use the SP's feedback. A mandatory workshop is provided to all SPs working for our college. We give a lecture-style introduction on the content and structure of the feedback session along with information about verbal and nonverbal communication. See Table 1 for additional lecture content in the condensed form of feedback "Do's and Don'ts".[1,18] This is followed by practice sessions where SPs role-play with several partners and then engage in small group discussions. We recommend 2-3 hours to conduct this workshop, depending on the SPs' familiarity with this topic.

The common denominator in SP feedback among disciplines is the focus on the interpersonal dimension. That

dimension is manifested chiefly through nonverbal communication, and therefore our SP feedback workshop emphasizes nonverbal components.

Following the lecture, in groups of 10-12, SPs view a brief clip of a student working in a simulation. The SPs are asked to imagine themselves in the encounter and then develop feedback points based on the video clip. Then, in pairs, the SPs discuss their ideas for feedback. We stress that it is important to never make assumptions regarding the motive(s) for any behavior(s) but instead to focus on how the SP experienced the student's behavior and its impact on care delivery.

Following this, the workshop shifts to role-play: One SP in the role of the student just observed and one in the role of feedback giver. Observers are assigned to focus separately on verbal and nonverbal behaviors. In this tightly facilitated educational role-play phase, the SP in student role is occasionally asked to pause and voice the inner thoughts and feelings of the student. This is to help the SPs develop empathy for the student's experience during feedback. During the role play process, the faculty facilitator deliberately models the attributes of good feedback (e.g., specific, behavioral, starting with the positive) when SPs need to modify how they are delivering the mock feedback.

To evaluate the utility of the workshop, a one-group pretest-posttest design was used, with 41 participating SPs. Two questions were posed on a visual analog scale, and responses later converted to a value based on 10 points. In response to the item "How confident are you in your ability to provide useful feedback to students after an SPL encounter?" there was an increase from a pretest mean of 8.32 to a mean of 8.99 at posttest. There was an increase from a mean of 8.47 to a mean of 9.09 in response to the question "How comfortable are you providing 1-to-1 feedback (in person, not just on the checklist) after an SPL encounter?" For both of these questions, approximately 1/3 of participants gave themselves a "10" at pretest, indicating a ceiling effect is likely in the data. Overall, participants rated the overall quality of the workshop with a mean of 9.11 out of 10. In addition, the SPs were asked what they felt they learned, and the major themes in their comments focused on the structure of a feedback session, attending to students' nonverbal behavior, and awareness of how to use the nonverbal aspect to improve communication with the student.

Conclusion

This article has presented our interdisciplinary approach to SP training for the delivery of feedback to students working in simulated encounters. Our workshop gives structure to the feedback session: it emphasizes the reflective process and attention to the nonverbal dimension. We hope that we have provided a simple and effective framework as well as an appreciation of the important role SP feedback plays in health professions education.

References

1. Mckimm J. (Internet). London, England: London Deanery; c2008 (cited 2010 May 17). Available from: http://www.faculty.londondeanery.ac.uk/e-learning/feedback/html2pdf. Accessed May 17, 2010.
2. Branch WT, Paranjape A. Feedback and reflection: Teaching methods for clinical settings. Acad Med 2002; 77:1185-1188.
3. Lockyer J. Multisource (360 degree) feedback and the assessment of ACGME competencies for Emergency Medicine Residents (webpage). American College of Graduate Medical Education, c 2000-2011. Available from: http://www.cordem.org/10aaa/2010Handouts/2010aaDay1/2010aa1LockyerMultiSourceFeedback.pdf. Accessed May 10, 2010.
4. Panzarella K, Manyon, A. A model for integrated assessment of clinical competence. J Allied Health 2007; 36:157-164.
5. Shaw GB. BrainyQuote.Com, Xplore Inc, (Internet) c 2001-2011 Available from: http://www.brainyquote.com/quotes/authors/g/george_bernard_shaw_9.html. (Accessed April 22, 2011).
6. Philpott P. The relative contribution to meaning of verbal and nonverbal channels of communication: A meta analysis. [MA Thesis] Lincoln, NE: University of Nebraska; 1983.
7. Knapp ML, Hall JA. Nonverbal Communication In Human Interaction. 5th ed. London: Wadsworth Learning; 2002.
8. Navarre D. Posture sharing in dyadic interaction. Am J Dance Ther 1982; 5:28-42.
9. Fraenkel DL. The ins and outs of medical encounters: An interactional analysis of empathy, patient satisfaction, and information exchange [dissertation] Rochester, NY: University of Rochester; 1986.
10. Fraenkel, D. Relationship of empathy in movement to synchrony, echoing and empathy in verbal interactions. Am J Dance Ther 1983; 6:31-48.
11. Newman M, Lorico A, Goodill S, Cheley L. Listening to our patients: The experiences of women undergoing acupuncture for polycystic ovarian syndrome. Presented at Society of Teachers of Family Medicine, Northeast Region Meeting; Oct 2000; Phila, PA.
12. Goodill, S. Nonverbal communication between an acupuncturist and her patients: Implications for the complementary therapies. Research poster session abstracts from the 1999 and 2000 conferences. Am J Dance Ther 2001; 33: 128-29.
13. Gallese V, Eagle MN, Migone, P. Intentional attunement: Mirror neurons and the neural underpinnings of interpersonal relations. J Am Psychoanalytic Assoc 2007; 55:131-176.
14. Berrol, C. Neuroscience meets DMT: Mirror neurons, the therapeutic process and empathy. Arts in Psychotherapy 2006; 33:302-15.
15. Dayer-Berenson, L. Cultural Competencies: Impact On Health And Illness. Sudbury, MA: Jones & Bartlett; 2010.
16. Bokken L, Linseen T, Scherpbier A, Van Der Vleuten C, Rethans, JJ. Feedback by simulated patients in undergraduate medical education: A systematic review of the literature. Med Educ 2009; 43:202-210.
17. Schlecht KD. Feedback. Int Anesthesiol Clin 2008; 46:67-84.
18. Pendleton D, Scofield T, Tate P, Havelock P. The Consultation: An Approach To Learning And Teaching. Oxford: Oxford University Press; 1984.

.

Date published: Mar 1, 2012.
Revised: —March 31, 2012 (order of authors' names)