Insight into undergraduate feedback of clinical practice: Junior Doctors vs Consultants

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Abstract

Background: Constructive feedback is essential to improve clinical practice and is therefore discussed extensively in educational literature. Despite this, students regularly express dissatisfaction with their feedback at medical school. Many challenges to feedback in clinical settings have been documented but few were based on the students perspectives. This qualitative study explores the students experiences of feedback in clinical settings, in their third year at Imperial College London.

Method: Seven third year medical students who were based at Hillingdon Hospital during February 2014 were interviewed in a semi-structured format on their experience of feedback in clinical settings. The interviews were transcribed and analysed using a thematic analytical approach.

Results: The students claimed that they received little feedback and usually in an ad-hoc manner. Feedback was inconsistent between different clinicians, confusing some participants. There was a marked difference in quality and quantity of feedback between the consultants and junior doctors, with the majority of students preferring feedback from juniors. Junior doctors feedback focussed on medical school assessments, whilst the consultants was geared towards daily clinical practice.

Discussion: Feedback provided by both clinician groups was heavily influenced by their own experiences and working environments. For consultants this was their vast clinical experience and considerable time constraints, whereas juniors had more time for students and could focus on exam techniques. Empowering students to take an active role in feedback, either seeking or clarifying the differences may be of help.

Conclusion: Though feedback from consultants and junior doctors is not aligned, both are useful in shaping future clinicians.
Introduction

Feedback is a cornerstone of medical education and a dominating theme of the literature since the pioneering paper by Ende (Bing-You et al., 2017). It is frequently discussed at medical educational conferences (AMEE, 2017) and is an important component of the UK General Medical Council’s guidance for promoting excellence in medical education (General Medical Council, 2016).

Yet according to the UK National Student Survey, the average satisfaction across all Medical Schools for timely feedback and helpful comments was 61% and 59% respectively (Higher Education Funding Council for England, 2017). Ende described feedback as a formative, integral part of a student’s learning process, allowing the student to remain on course in reaching their goals (1983). It is the conduit through which good practice is reinforced and poor performance is modified (Cantillon & Sargeant, 2008).

Numerous factors have been described in the literature that hinders delivery of feedback. These can be categorised into teacher (e.g. lack of knowledge and experience) (Cantillon & Sargeant, 2008) student (e.g. unreliability of using student satisfaction as a metric) (Boehler et al., 2006) and logistical (e.g. time and place restraints) (Ramani & Krackov, 2012) factors.

Though different approaches to feedback have been suggested and explored with students, few studies looked at the students’ experience in a clinical setting. The aim of this study was to explore the experience of third year medical students in receiving feedback on their clinical placements and investigate reasons for any dissatisfaction.

Method

Context

At Imperial College London, the first two years are pre-clinical studies, with third year comprising three ten-week hospital placements. They are assessed at the end of the year with written and practical examinations, where they are expected to show competencies in basic history taking, examination and clinical skills.

Study design

In this qualitative study, we used semi-structured interviews to explore individual experiences of receiving feedback. The interviews were transcribed and the data was analysed using a thematic analytical approach. Open and axial codes (as per Strauss and Corbin) were generated to identify the themes (1990). The students’ responses were anonymised, assigning each participant with a number.

Participants

Participants were recruited on a voluntary basis. The recruits were third year medical students at Hillingdon Hospital in February 2014. Seven students (males and females) participated.

Ethics
Ethical approval was granted by the Medical Education Ethics Committee of Imperial College London (MEEC1314-11). We also obtained permission from the Research and Development Department of Hillingdon Hospital.

**Results**

We focused on the feedback challenges the students reported and have identified three main themes; sporadic feedback, inconsistent feedback and varying quality of feedback.

**Sporadic Feedback**

All study participants felt that they received insufficient feedback. One student took the initiative of actively seeking feedback from a clinician while many did not, unless there was a reinforcing factor such as a course requirement or recognition (Fig: 1).

> “Unless you talked to your Consultant or unless you were lucky enough to have F1’s or junior doctors who were interested in giving you teaching and feedback on your skills, it is probably quite hard get feedback.” S4

> “I know people who are equally talented and interested as me, ... that don't get feedback because they are not as proactive, because they are intimidated by going up to Junior Doctors to ask them to watch them doing procedures.” S4

> “These supplementary forms where you can ask other members of the team to sign for you, it is quite rare that anyone actually asks because it is not a requirement, there is no extra points or extra recognition for getting additional sign offs.” S6

Figure 1: Students’ quotes on sporadic feedback

**Inconsistent Feedback**

The students were given inconsistent feedback by different clinicians. This differed from teaching they had previously received and some found this confusing.

> "Everyone has different techniques, so there was always that area of ‘Why did you do that?’ and it's like ‘Because that is what I was taught’”. S4
Interestingly, there was a distinct difference in feedback from consultants and junior doctors. Some students preferred the focus of the junior doctors (Figure: 2).

**Student response to inconsistent feedback**

We explored the ways that the students responded to this diverse feedback (Figure 2). Though the feedback was incongruent, they did not mention this to the teachers. Instead, they tailored different approaches depending upon the teacher at the time. Some chose to only accept feedback from someone they could trust. One student mentioned someone ‘closer to the medical school’, who turned out to be a more senior medical student. In contrast, a few students managed to understand the context of the diverse feedback without hindering their overall learning.
Students perceived a distinct difference in the content of feedback between consultants and junior doctors (Table 1). Students consistently highlighted generic feedback from consultants. More value was placed on junior doctors’ input.

<table>
<thead>
<tr>
<th>Consultants</th>
<th>Junior doctors</th>
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<tbody>
<tr>
<td>“Consultant quite often just about ask you, how do you think you have been doing and then, whatever you say, is what goes on the form”. S3</td>
<td>“More a constant feedback process from them, we never really have a sit-down thing at the end of the firm”. S6</td>
</tr>
<tr>
<td>“Medical student should do this and its quite generic feedback especially with the sign off forms”. S6</td>
<td>“Juniors are better at giving more in depth feedback”. S7</td>
</tr>
<tr>
<td>“I have not heard a single consultant yet actually say, yes, you were good on this point, or you could improve in this area”. S6</td>
<td>“I think you get to know the Juniors a lot better and therefore they give more feedback”. S3</td>
</tr>
</tbody>
</table>

Table 1: Quality of feedback between consultants and junior doctors
Students’ interpretation of the varying quality of feedback

We explored the students’ beliefs into the reasons of different approaches between consultants and junior doctors (Figure 3). They identified consultants lack of time and direct observation of students as the key factors.

“Juniors generally a lot more aware of what the curriculum is like and what areas you need to focus on for your exams”. S6

“We had a good consultant who was interested and got engaged with us ... but ... he never really saw us examine a patient, he never saw us ... practicing actual skills.” S4

“Some of the consultants have skipped out a lot of the parts of examinations because I suppose they are a lot more keen eyed”. S1

“[Junior doctors] have a lot of down time, so they can spend a lot more time with you, to talk over what you need to improve”. S6

“One of the attachments that I did the consultant was only in the hospital one afternoon a week to do a clinic when we didn't even sit in his room with him during the clinic, so that feedback wasn't really so valuable because we felt like the consultant didn't really know us that well, hadn't spent much time with us”.S6

Figure 4: Students' views on causes of varying feedback

Discussion

We found that the students experienced inconsistent feedback in clinical settings, with a marked difference between the feedback of consultants and junior doctors. Feedback from junior doctors was impromptu and regular
throughout the attachment, while the feedback from consultants was formal at the end of their placement. Our discussion focuses on exploring these differences.

**Time**

The participants noted that more of their time was spent with junior doctors rather than consultants. This continuity of observation allowed junior doctors to accrue a more detailed account of their students’ performance and expectations. As a result, feedback was perceived as being more comprehensive. Ende argued that ‘observation is the currency of feedback’ (1983 p:778). Our data demonstrated that without sufficient observation, feedback becomes increasingly generic and less personal (Table 1).

Conversely, consultants were noted to spend less time observing students. This may be due to two reasons. Firstly, consultants are increasingly dealing with administrative work and managerial roles in addition to their clinical and teaching duties (Appleby, 2017). Secondly, consultants may devote their limited time with students to deliver teaching rather than observing and providing relevant feedback. Further studies could explore the consultants’ perception of this matter.

**Content of feedback**

Junior doctor's feedback tended to be oriented towards helping students achieve exam success, whereas consultant feedback revolved around developing efficient clinical practice. This difference impacted the reception from students. With students expected to prepare standardised approaches for their examinations, they welcome feedback that helps them achieve this. Although less clinically experienced than consultants, junior doctors seemed better equipped to fulfil this learning need due to their more recent experiences of undergraduate assessments.

**Different level of experience and approximation to juniors**

It is likely that due to their longer experience consultants can extract the information needed for clinical decision making from more focused examinations. In clinical practice, this approach increases efficiency, but can confound medical students, whose training emphasises systematic, thorough examinations. Students reported receiving feedback from consultants that, at times, appeared to contradict what they had previously been taught.

Feedback that contradicts previous learning could be demoralising and counterproductive. Exploring the students’ understanding and explaining the reasons for difference in practice may enhance learning. Students could be encouraged to clarify differences in practice and engage in discussion with their clinical teachers which may foster a deeper understanding of the subject.

Junior doctors, being closer in time to their undergraduate training, are more likely to adopt clinical approaches that align with what students have been taught. Students will appreciate that junior doctors have recently successfully navigated the myriad of challenging assessments and portfolio requirements of medical school. It is likely that students will envision their role in the near future to be closer to that of a junior doctor than a consultant. As per Bandura's social learning theory, learners are more likely to attend to and imitate those they perceive as being similar to themselves, who fulfill a role closer to theirs (1991).

**More training at medical school**

Medical school curricula have changed since the implementation of ‘tomorrow’s doctors’ by the General Medical Council (General Medical Council, 2016). Teaching and training students became the responsibility of doctors of all grades. In order to equip the next generation of doctors with these skills, medical schools often incorporate courses
on teaching and feedback delivery. Perhaps this training at the undergraduate level is a factor contributing to the thorough feedback given by junior doctors, as perceived by medical students.

Student Initiative

Most of the literature and initiatives surrounding feedback focus on the role of the teacher in its delivery. However, as highlighted by one of our students, taking the initiative to actively seek feedback, outside compulsory forms, can be a highly effective method in maximising learning opportunities in clinical settings. Therefore, students could be encouraged to take an active role in their feedback.

Limitations and wider implications

Sample size was limited to seven participants. Therefore, we cannot generalise our findings to the whole cohort of students. But this study has improved our understanding on the feedback challenges faced by the students in clinical settings, enabling us to produce some recommendations.

We did not explore the students' contact time with each group of doctors, their seniority or specialities. These factors may influence feedback delivery and this may be worth further study.

Though all our study participants were from one university, the authors shared similar experiences at other institutions as undergraduates. Therefore, we believe the issues raised are common to many medical schools and a multi-institutional study could help determine the extent of these issues.

Conclusion

We conclude that feedback from both consultants and junior doctors is helpful for the development of medical students. Students preferred the junior doctors’ feedback relating to their medical school assessments. We believe that the consultants’ feedback is equally important in guiding them for their future roles as clinicians and fostering approaches needed to be an efficient clinical practitioner. Thus, feedback from both parties is essential for the students’ development. Efforts should focus on helping students understand this duality and encouraging them to take an initiative in seeking or clarifying feedback from clinicians. This will result in greater quantity and improved perceptual quality of feedback and ultimately ameliorate student satisfaction.

Take Home Messages

Initiatives could be implemented to gain benefit of feedback from both junior doctors and consultants. We have introduced a session at the beginning of the students' placement highlighting the discrepancies and demonstrating how feedback from both groups of doctors could benefit their development. Organising drop-in tutorials to all doctors on the basic principles of feedback in clinical settings and better communication on undergraduate curriculum requirements may also be helpful in minimising the feedback dilemmas faced by students.
Notes On Contributors

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Appendices

Declarations

The author has declared that there are no conflicts of interest.

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