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Brief Report

Collaborative and Bidirectional Feedback Between Students and Clinical Preceptors: Promoting Effective Communication Skills on Health Care Teams

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Current literature on feedback suggests that clinical preceptors lead feedback conversations that are primarily unidirectional, from preceptor to student. While this approach may promote clinical competency, it does not actively develop students' competency in facilitating feedback discussions and providing feedback across power differentials (ie, from student to preceptor). This latter competency warrants particular attention given its fundamental role in effective health care team communication and its related influence on patient safety. Reframing the feedback process as collaborative and bidirectional, where both preceptors and students provide and receive feedback, maximizes opportunities for role modeling and skills practice in the context of a supportive relationship, thereby enhancing team preparedness. We describe an initiative to introduce these fundamental skills of collaborative, bidirectional feedback in the nurse-midwifery education program at the University of California, San Francisco.

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INTRODUCTION

In 2015, the American College of Nurse-Midwives; the American College of Obstetricians and Gynecologists; the Association of Women's Health, Obstetric, and Neonatal Nurses; and the Society for Maternal-Fetal Medicine jointly issued a blueprint for transforming communication and safety culture in intrapartum care.[1] One explicit recommendation was to establish a team and organizational climate where skillfully "speaking up" is the norm and the development of communication skills, including feedback, is prioritized. Though not explicitly mentioned, clinical educators and education programs are well poised to answer this call. We propose that attention to the structure and process of feedback within student-preceptor relationships promotes this fundamental team communication skill. We also describe a practical intervention implemented by the University of California, San Francisco (UCSF) nurse-midwifery education program.

EFFECTIVE FEEDBACK PROCESS

Feedback is specific, nonjudgmental information, comparing performance with a standard, with an intention to improve performance.[2] Students and faculty alike must incorporate feedback to develop expertise in clinical and educational work.[3] A growing body of literature in health sciences education informs the provision of effective feedback to adult learners. In particular, goal setting, specificity, and increased frequency of feedback enhance its effectiveness.[4] Of additional importance is the inclusion of learner self-assessment, which promotes accountability, application of feedback, and the capacity for self-assessment.[5,6] In the clinical setting, a preceptor giving effective feedback: 1) asks the learner to initiate the session by identifying goals, 2) asks the learner to self-assess their skills, and, finally, 3) names observations and specific behaviors related to the goals.[4–6]

Receptivity and trust strongly influence the effectiveness of feedback between students and faculty. Medical students generally do not elicit feedback from clinical supervisors unless specifically coached; when they do, they prefer to ask faculty perceived to be more approachable than expert.[7] A qualitative study of midwifery students, medical trainees, and practicing physicians found that feedback recipients responded more positively when they believed feedback providers to be motivated by goodwill.[8] This finding should not be confused with an endorsement of praise ("good job!"), which preceptors often use in an effort to increase student satisfaction. Specific feedback that is reinforcing, corrective, and/or given in the context of a trusting relationship is associated with attainment of educational goals.[8–10]

For preceptors and students functioning within time-limited relationships and busy clinical environments, effective feedback must not undermine the ability to fulfill other responsibilities. An effective feedback process will therefore incorporate the core elements of goal setting, self-assessment, and specificity while also enabling rapid establishment of a trusting relationship. According to the Ask-Respond-Tell feedback model (Table 1), preceptors invite students' self-assessment, respond with reflective listening and empathy, and tell their perspective.[11] This conversational approach differs from the more common "download" and helps to establish partnership.[12] While other models also incorporate a dialogic approach and acknowledge the importance of student perspective, Ask-Respond-Tell additionally emphasizes the explicit expression of empathy, which is known to build relationships and, specifically, trust.[6,13]

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Quick Points

- A paucity of bidirectional feedback skills impairs interprofessional team function and negatively impacts patient safety.
- In order to develop students' competency in team communication, student-preceptor feedback provides opportunities for students to participate actively in the process, as both recipients and providers of feedback.
- Successful application of this collaborative and bidirectional feedback process requires individual skill development as well as programmatic support.

COLLABORATIVE AND BIDIRECTIONAL FEEDBACK ON TEAMS AND ACROSS POWER DIFFERENTIALS

When evaluating the effectiveness of feedback, it is important to consider the student-preceptor relationship in the broader context of interprofessional teams.[14] Effectively providing and receiving feedback are core competencies of interprofessional collaborative practice.[15] A well-prepared midwifery graduate knows how to assess the fetal heart rate and also how to effectively engage in dialogue with nursing and physician colleagues, who may reach different conclusions about fetal status and related management decisions. As skillful clinicians and skillful team members, these graduates are able to communicate effectively in the interest of team function and, ultimately, patient safety. Designing the structure and process of feedback within student-preceptor relationships presents a valuable opportunity to prioritize these dual and complementary competencies.

Power differentials influence the effectiveness of feedback by limiting the extent to which less powerful team members share their perspectives.[16] Formal hierarchies can be especially complex for midwives, who find themselves in a middle space between nurses and physicians and for whom philosophically distinct models of care may result in conflict.[17] As perceptions of power fluctuate according to context and team composition, team members often disengage, with consequences for patient care.[16,18] In a survey of midwives, nurses, and physicians, Maxfield et al[19] found that only a small minority reported speaking directly to an involved team member about a safety concern.

The student-preceptor relationship is characterized by a similar power differential. There is disparity in skill and experience and, importantly, a hierarchy of roles and responsibilities, which typically invest the preceptor with the power to summarily assess the student's competency. There may also be differences in identity (including but not limited to racial, cultural, socioeconomic, gender, and sexual identities) that compound this effect. For example, white preceptors may be especially reluctant to provide corrective feedback to students of color due to concern about conveying bias, while the students themselves may avoid feedback interactions due to prior experiences of alienation from the educational system.[20] Consideration of social context, including culture, values, and power, is therefore essential to understanding both the process and impact of feedback encounters.[9] If this understanding is to yield an educational alliance, both students and preceptors must actively engage.[12]

REFRAMING THE ASK-RESPOND-TELL MODEL

For students and preceptors, the opportunity to establish a goal-oriented alliance across power differentials is comparable to the dynamics of a health care team; it therefore represents a promising laboratory for feedback skill development. Competency can develop through both role modeling by the preceptor and by the student's assumption of shared responsibility for the process.

To promote this collaborative approach, we propose a reframing of the Ask-Respond-Tell model (Figure 1),[11] which allows preceptors and students to jointly facilitate the process and feedback to be bidirectional. Table 2 describes this process. Following a clinical encounter, the preceptor can initiate the feedback conversation by asking the student for self-assessment: "Considering the goal you established at the beginning of our session, what do you think you did effectively, and what would you do differently?" After the first cycle of feedback, the preceptor initiates the second cycle, including her or his own self-assessment: "Let's consider how I supported you in meeting your goals and what I could do

Table 1. Ask-Respond-Tell Feedback Model

Step	Examples
Ask the learner about goals and self-assessment.	"What specific skills are you working on? What would you like me to focus on in my feedback to you?" "Tell me what you did effectively in that interaction and what you might do more effectively next time."
Respond to the learner's perspective with reflective listening and empathy.	"I agree that clarifying the warning signs of preterm labor will be important for you to learn in this rotation." "Yes, I can understand feeling overwhelmed when the problem list is long and the visit time is relatively short."
Tell your perspective.	"I wonder if, instead of attempting to address all of the problems in one visit, you could find a way to work collaboratively with the patient in setting priorities for the agenda."

Source: Connor DM, Chou CL, Davis DL.[11]

differently next time. My perspective is …" In both cycles, feedback is preceded by a reflective and empathic response to the self-assessment. This emphasis on empathy fosters alliance building, as the student both experiences empathy and develops skill in its expression, with potential benefit for team function.[21,22]

An added benefit of this bidirectional approach is to inform preceptor development in real time, when feedback is actionable and results can be more readily appreciated than those generated through anonymous, delayed written feedback.[23] Understanding the student's assessment of the educational alliance enables the preceptor to build the alliance further, with potential to enhance the effect of future feedback encounters.[12] Role modeling continues as the preceptor demonstrates timely and effective incorporation of feedback into her or his teaching. By inviting feedback and receiving it gracefully, preceptors role model vulnerability across power differentials as a professional skill, with potential application to interprofessional team relationships. For example, a meaningful parallel can be drawn between a preceptor's elicitation of feedback from a student and that student's elicitation of feedback from a nurse about communication during an obstetric emergency.

ADDRESSING BARRIERS TO IMPLEMENTATION BY STUDENTS AND PRECEPTORS

It is important to recognize that both students and preceptors will have varied degrees of comfort with a collaborative and bidirectional approach to feedback. Preceptors may have experienced a different model as learners themselves or work in a clinical environment where feedback behaviors range from dysfunctional to threatening. Well-documented evidence of disconnection, unresponsiveness, and resignation among interprofessional teams in the intrapartum setting necessitates thoughtful consideration of this barrier.[18] Mentorship, perhaps among peers, may be especially important for these preceptors.

Students may be reluctant to assume an active role in the feedback process, especially in the provision of constructive feedback across a power differential. Thus, they may need repeated and explicit invitations by their preceptors to participate in these ways. An example might be: "When I was a student, I remember struggling with how to give feedback to one of my preceptors. I wish I had said something like, 'I find it difficult to tell you that I don't know something. It might help if you checked in about my confidence level before we discuss my management plan.' What similar things would you like to say to me?" Preceptors' self-assessment is especially important in these relationships as it offers an opening, and perhaps specific language, for the student to emulate. Students' and preceptors' open communication about the feedback process informs mutual goal setting and, ultimately, shared development of competency in providing and receiving feedback.

Implementing and maintaining this collaborative and bidirectional feedback model is undoubtedly complicated by the varied demands of a clinical learning environment, including time restrictions and limited opportunities for student-preceptor continuity. As with any novel skill, establishing a shared understanding and comfort with the feedback process may be time intensive at the outset, with increasing efficiency through repetition. In settings where learners work with multiple preceptors, especially preceptors who are dispersed in the community and potentially less familiar with the feedback culture of the education program, students may be well positioned to act as feedback ambassadors. In addition to representing their learning goals, they can also augment program efforts to orient preceptors to the process. Milan[7] described a successful intervention to promote feedback seeking on the part of third-year medical students. Following a 90-minute interactive feedback workshop, which addressed learners' demonstrated receptivity to, as well as solicitation of, feedback, student participants reported more feedback-seeking behavior than control subjects. These findings suggest that even a brief intervention has the potential to activate students. However, given students' lower position in the hierarchy, they cannot reasonably be expected to assume the role of primary change agent in an inhospitable feedback culture.

PROGRAMMATIC DEVELOPMENT

Because the implementation of a more collaborative and bidirectional approach to feedback likely represents a significant cultural change, it requires programmatic and structural support in addition to individual skill development. Henderson[24] described a yearlong medical education curriculum to develop individual feedback skills as well as to promote a work culture where bidirectional feedback across hierarchy is a norm. The model emphasizes skills practice between peers and in small groups, with both student self-assessments and faculty summative assessments documenting students' skills in providing and receiving feedback. This demonstrated value of peer and supervisor group learning environments can be applied directly to the development of feedback skills within clinical learning relationships. Instead of learning feedback skills separately, students and preceptors can be supported to develop this highly relational skill in a group that is integrated across the supervisory hierarchy. Students and preceptors can then be oriented to the process in ways that embody the key principles of collaboration and reciprocity.

We initiated, and herein describe, a clinically focused application at our institution. The UCSF nurse-midwifery education program was founded in 1977 and graduates approximately 15 nurse-midwives each year. The primary clinical site is Zuckerberg San Francisco General Hospital and Trauma Center, staffed by a group of 11 core midwifery clinical faculty, many of whom are graduates of the UCSF program, with between 10 and 32 years of professional experience. Prior to 2014, programmatic support for the feedback process mainly included separate workshops for students and faculty as well as case-specific mentorship of both students and faculty in challenging feedback relationships. Summative, written program evaluations by students suggested that while many students found relationships with clinical faculty to be supportive and feedback to be effective, some students were dissatisfied with what they perceived to be nonspecific or judgmental feedback and also struggled with communicating their concerns directly to clinical faculty.

In the fall of 2014, UCSF midwifery clinical faculty and students piloted a new approach to feedback skill

Table 2. Examples of the Application of a Collaborative and Bidirectional Feedback Process

Roles	Self-Assessment	Reflective and Empathic Response	Constructive Feedback	Goal Setting
Family planning visit				
Preceptor as feedback provider	Student: "My familiarity with family planning options is strong, but it was difficult to engage the patient in discussing her plan."	Preceptor: "You've worked hard to develop your knowledge base. It takes practice to effectively individualize your approach."	Preceptor: "I noticed that the patient didn't talk much. Perhaps starting with an open-ended question would have invited more participation."	Student: "Okay. Next time I'll start by asking the patient about her past experience with the methods."
Student as feedback provider	Preceptor: "Our preparatory discussion about risks and benefits seemed to help you organize your counseling. I noticed the patient directing most questions to me and wondered how I may have contributed to that dynamic."	Student: "Even during a busy clinic, you took the time to help me talk through key points, which built my confidence."	Student: "At first, you stood back and let me assume the primary role. Once the patient asked you a question, it did seem like you assumed responsibility for the counseling."	Preceptor: "I really appreciate your observation. Next time I'll be more deliberate about redirecting the questions to you."
Birth with postpartum hemorrhage				
Preceptor as feedback provider	Student: "I was focused on assuming primary responsibility as the midwife in the room. The postpartum hemorrhage made that more difficult, but I felt like I was able to take the initial management steps on my own."	Preceptor: "That was a challenging birth. Even in a stressful environment, you were able to clearly diagnose the hemorrhage and communicate effectively with the nurse about the need for misoprostol."	Preceptor: "When the bleeding continued, you redirected your attention to performing fundal massage. At that point, I thought bimanual massage was indicated."	Student: "That was the first bimanual massage I've seen. Can we find a time to talk through the skill before the end of the day? I would like to feel better prepared for completing it independently next time."
Student as feedback provider	Preceptor: "Recalling your feedback from our last session, I really tried to stand back during the birth. There were several times when I redirected the patient's questions to you."	Student: "I appreciated your efforts, and I think they enhanced the family's trust in me."	Preceptor prompts corrective feedback: "I'm wondering about our interaction during the hemorrhage. For safety reasons, I felt I needed to take over for the bimanual. What was the impact on you?" Student: "I know safety is our priority, so I understood." Preceptor prompts again: "What could I do differently next time that might address the need for safety and also promote your independence?" Student: "If possible, it would be helpful for you to talk through the steps as you're doing them." Preceptor: "Okay, what else?" Student: "Once the bleeding stabilized, I wasn't sure how to step back into the primary role or what you expected of me for the remainder of the fourth stage."	Preceptor: "That's helpful information. I also wondered what you needed from me. When we set our goals for the next session, let's talk more about how we can communicate effectively in those moments."

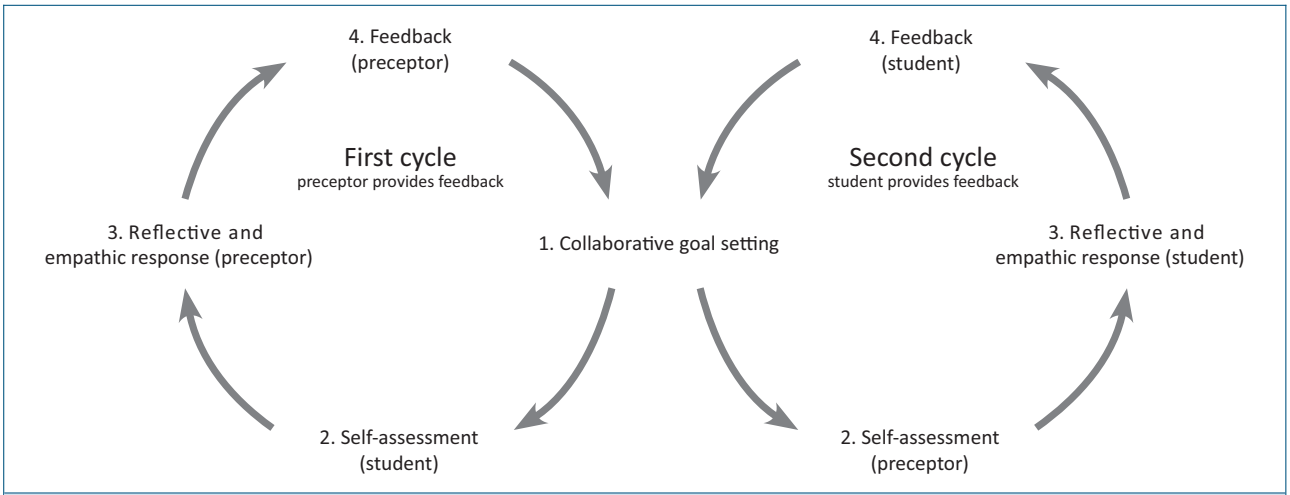

Figure 1. Collaborative and Bidirectional Feedback Process

The collaborative and bidirectional feedback process includes 2 cycles of feedback. In the first cycle, the preceptor is the feedback provider, and the student is the feedback recipient. In the second cycle, the roles are reversed. Collaborative goal setting (1) initiates both cycles, which then proceed through the following steps: (2) self-assessment, composed of reinforcing and constructive elements; (3) reflective listening and empathic response; and (4) feedback, again composed of reinforcing and constructive elements. Both cycles inform ongoing collaborative goal setting (restarting at 1) for subsequent clinical encounters.

development with an integrated, half-day workshop. The workshop included large group didactics and demonstrations but was primarily focused on facilitated small group skills practice, specifically role play, as an evidence-based educational tool for communication skill development.[25] In 4 groups of 6 to 8 students and preceptor faculty, distributed approximately half and half between groups, facilitators trained through the American Academy on Communication in Healthcare guided participants through role plays of common feedback scenarios, using cases generated by the participants themselves. Participants practiced each step of the model (Figure 1), including the provision of both reinforcing and constructive bidirectional feedback. Debriefing allowed for additional skills practice by including participants' self-assessments as well as feedback from peers and other group members. These public feedback opportunities supplemented the simulated exercises with real-time encounters, promoting self-awareness through recognition of one's impact on and response to fellow group members.[24]

At the conclusion of the workshop, participants completed a written, anonymous evaluation. Both faculty and students emphasized the value of the integrated learning environment, specifically the opportunity to practice feedback skills together. In setting intentions for change, the students used language representing themselves as active facilitators of the feedback process. For example, one student indicated that she would "be more confident in asking for the feedback [I] need, especially in asking [my] preceptor to self-assess and give [me] an opportunity to give her feedback as well." As a means of systematically reinforcing the facilitated skills practice, daily clinical evaluation forms were modified to be consistent with the model and include an elaborated prompt for faculty self-assessment and detailed feedback for faculty by students. Students identify aspects of the student-preceptor interaction that facilitate and hinder their goal attainment and also suggest means of enhancing the interaction. Preceptors specify which teaching strategies they would like to "keep, stop, and start" (See Supporting Information, Appendix S1).

The UCSF nurse-midwifery education program's efforts to design an effective feedback skills curriculum are ongoing. Successful transformation of communication and safety culture calls for a longitudinal approach.[1,24] Integrating ongoing, group-based learning opportunities has proven difficult in the context of busy curricula and clinical services. Efforts to identify opportunities for facilitated skills practice include contemplation of refresher sessions, which will focus on role play and debriefing. Based on student and preceptor feedback, the timing of the initial workshop has been modified to allow for earlier skill development in the course of the 2-year midwifery program. This adjustment also allows more time for reinforcement, both formally and informally.

CONCLUSION

Clinical preceptors have traditionally been represented as stewards of the feedback process and, in some cases, the assumption of this role is appropriate. However, it is unnecessarily limiting to uniformly appoint preceptors as primary facilitators of all feedback encounters or to routinely engage in unidirectional feedback. As students prepare to be effective communicators on interprofessional teams, they require opportunities to practice related skills, including feedback, in the context of supportive relationships. Students' feedback competency can be promoted through both programmatic efforts and individual skill development. Future research efforts should examine specific training and maintenance interventions for preceptors and students, as well as the effects of these interventions on measured competency in feedback. These efforts should integrate with the related and broader research endeavor of identifying practices that support effective feedback behaviors on interprofessional teams.[9] In summary, we advocate strongly for reframing the

feedback process toward bidirectional delivery as a means of improving role modeling, combatting the silencing effect of hierarchies, and ultimately, enhancing team performance.

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CONFLICT OF INTEREST

The authors have no conflicts of interest to disclose.

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SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article at the publisher's Web site:

Appendix S1: UCSF Nurse-Midwifery Education Program Evaluation Form

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