Editor's Page: We've been thinking...

Constructive Criticism in Medicine: Heart Function Clinicians Leading Positive Change

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Clinical rotations on the Heart Failure/LVAD/Heart Transplant services can be busy. They often demand our total immersion – managing complex hemodynamic perturbations, coordinating extracardiac care with consultants, getting to know the intricacies of patients' personalities and support systems. Clinician fulfillment and heartache are often commingled in any given day with the rejoice of lifesaving triumphs and lament of those lost or who could not be helped. We function in teams of residents, fellows, nurses, pharmacists, coordinators and attendings as one, to ensure the best possible care of our patients. In the process, a certain kinship forms in the simultaneous experience of intense learning, sharing, and caring for others.

Eventually, the clinical rotation comes to its inevitable end. Amidst the busyness of tying things up for the next team and the processing of emotions and fatigue, we often hear or relay the following:

> "Great job this week – I enjoyed working with you." And then part ways.

How many times have we given (and/or received) this type of "feedback" after clinical service?

Whether from the perspective of attending, fellow, senior or more junior trainee, this approach leaves much room for improvement.

Now, envision a scenario wherein a clinical team provides consistent 360-degree constructive feedback throughout the week. Such a team strives to not only provide optimal patient care but also to allow the betterment of each member of the team. Rotations begin with bidirectional assessments as to intention, learning objectives, and expectations for the week(s) ahead to inform a meaningful starting point. Such an approach takes training, time, and requires a frameshift in the culture of medicine. But amidst the current culture in clinical medicine all too familiar with burnout, wouldn't we as clinicians, as learners, and as teachers be better off along with the patients receiving our care?

Several challenges to the provision of routine constructive feedback in medicine exist and need to be acknowledged:

1) Lack of training on how to convey bidirectional feedback effectively;
2) Limited time for routine incorporation of feedback during a busy week of clinical service;
3) Contemporary reliance on standardized electronic evaluation forms;
4) A hierarchical structure that may limit bi-directional and/or 360 evaluations; and
5) A culture of conflict avoidance and general fear of being wrong or judged.

In truth, none of these are unique to medicine, yet repercussions of not providing helpful feedback can have detrimental consequences unique to the culture of our discipline. As trainees advance from one rotation to the next, year upon year, with-out insight into areas for improvement or guidance on affecting positive change, their future trainees and practice may be impacted accordingly. Once more established, receipt of feedback often becomes

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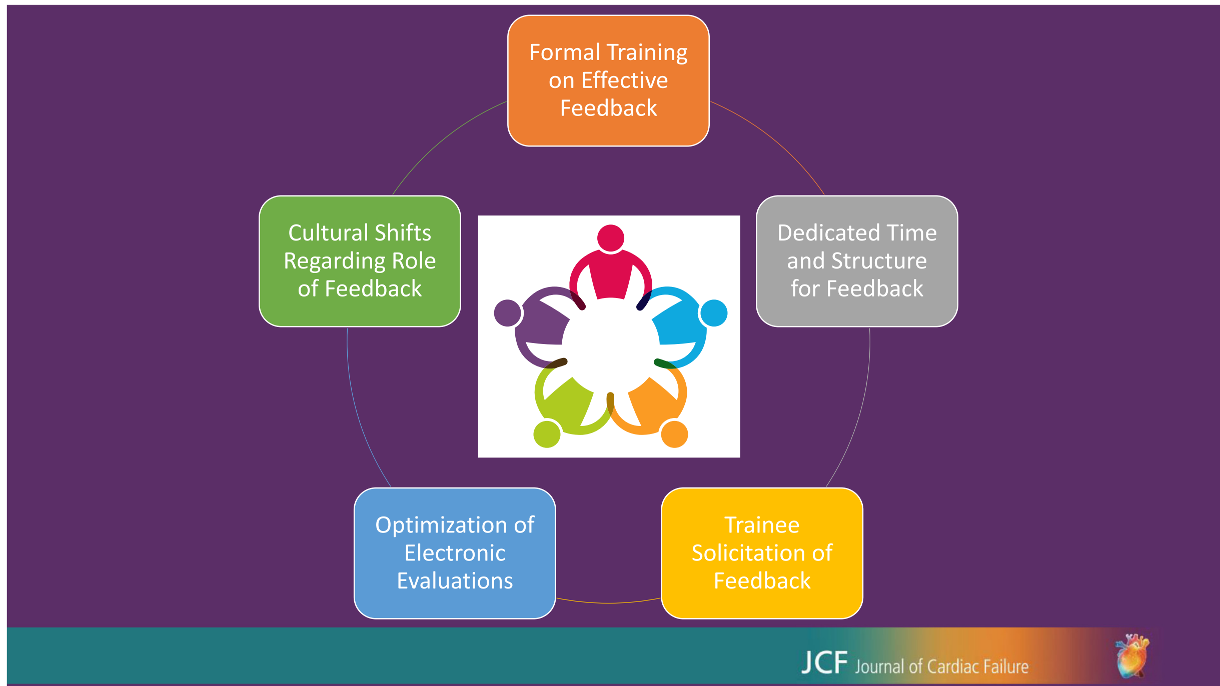

Figure 1. Several Components of a Roadmap to Reform for Feedback in Clinical Medicine.

even more rare. Leaders may become even less attuned to blindspots as their careers progress while simultaneously fewer voices feel comfortable providing evaluation. Each of these aspects may contribute to a negative work culture, enhanced burnout and worse patient care.

So, we've been thinking...Can the heart failure community be leaders in medicine for providing constructive feedback?

Several components of a roadmap to incorporate this into our daily and weekly rhythm are outlined below (Figure):

1) **Dedicated training sessions with experienced leaders on how to routinely provide effective feedback.** Upstream training on feedback could be beneficial at the earliest stages of medical training. Heart failure teams at individual institutions can execute dedicated educational discussions led by local leaders with expertise in feedback provision. Importantly, recurring events at a quarterly cadence may help to better instill and reinvigorate this culture of feedback amongst the team. The Heart Failure Society of America and other cardiovascular societies provide annual scientific session content that focuses on career development in these areas. Online training opportunities, dedicated coursework and prior literature[1-3] can be explored for individual development to complement group engagements.
2) **Dedicated time for feedback needs to be carved out *a priori* from a busy clinical schedule.** Effective examples may include a routine weekly team meal and 1:1 coffee breaks to pause for a moment of discussion with group and individual feedback, respectively. Unfortunately, these engagements often seem to be the first to get dropped when a large number of new admissions occur overnight or one of the trainees is post-call and needs to meet duty hour restrictions, etc. It may also be necessary to schedule these for the week after a busy service time when calendars may offer greater flexibility.
3) Trainee solicitation of feedback. We've recently had trainees that challenged us to do better through their requests of "What did you notice this week that I can work on to be better?" Can this inquiry become the norm?
4) **Modification standardized electronic evaluation forms which** may be insufficient to convey the nuance of feedback. Nonetheless, it may be helpful to routinely review and revise the content and structure of these forms to optimize their use. For instance, the highest yield free-text sections on "areas for improvement" are most commonly at the end of the forms when the reviewer may be least likely to spend time crafting text with meaningful feedback. Also, there can be wide variability in the number of reviews that an individual receives. Can we work as a community to more consistently complete these evaluations in a high-quality manner such that all parties benefit? As individuals routinely receive more effective feedback, will this create a positive feedback loop where

those receiving feedback improve their provision of feedback as well?

5) Finally, and perhaps most importantly, there are some **cultural shifts within medicine** that may need to occur in order to support refreshing our approach to evaluations and feedback. We need a culture of 360-degree feedback not just a top down approach. Can we work to mitigate concerns of retaliation for provision of negative feedback? Can we work toward a paradigm shift where critiques are not viewed as personal failure or inadequacy but rather a representation of respect and investment in the betterment of the individual being provided the feedback?

While outlining proposed concepts for improvement in this space may be easy to write out on paper, the work is in the execution. Both of us serve on clinical services and we have certainly been guilty of not providing the kind of feedback proposed. But we are committed to doing better and believe the exemplary clinicians in heart failure can lead the way, striving to be the change we wish to see.

In the spirit of feedback, we are open as editors to hearing your feedback as well, Let us know your thoughts!

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