

# DocTalks Ep 8 - Dr Clare Hutchinson

DocTalks: A Medical Learning & Teaching Podcast

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**Curtis Maloley:**

Welcome to DocTalks. I'm Curtis Maloley

**Heather MacNeill:**

and I'm Heather MacNeill. Joining us today is Dr. Clare Hutchinson. She's a pediatrician at North York General Hospital specializing in general pediatrics and pediatric rheumatology. She's also the Interim Assistant Dean, Curricular Innovation in undergraduate medical education at the TMU School of Medicine. So Clare, Welcome to DocTalks.

**Dr. Clare Hutchinson:**

Thank you for having me.

**Curtis Maloley:**

All right. Why don't we start with your clinical and teaching context? Can you describe your current role at North York General and how you work with learners across different settings?

**Dr. Clare Hutchinson:**

For sure. So North York General is a busy site with lots of different learners, but I'd say the primary place where I work with learners is in a team on the pediatric ward. So typically we'll have one or two residents from a variety of different programs, typically Junior residents from pediatrics, family medicine or emergency medicine, and then also that medical students either who are doing their third year clerkship, who are returning for a fourth year elective. So we may have a team of three to four trainees altogether. Sometimes we also have a senior pediatrics resident, so that's a team based learning approach. And then when we're in clinic, we do a pediatric consultation clinic, and I have a rheumatology clinic. Often you'll be working one on one with another learner, that, again, could be anywhere from a CC3 clerk up to a PGY-4 pediatric resident.

**Heather MacNeill:**

So we're really excited to have you today, especially as the Interim Assistant Dean of Curricular innovation, to talk about this concept of feedback, and when you know, when we're talking about teaching and learning, that is one of the core pillars of what we do, is feedback. And of course, you know, we've talked about how there's a ton of different models that we can all use when talking about feedback, and whenever we have a ton of different models, that means all of them are good, but in different ways, different ways of using them, or different contexts. I know before we've talked about kind of the R2C2 model, and the [inaudible] model. But can you talk a little bit about particular frameworks that you like to use when giving feedback and why you like those models?

**Dr. Clare Hutchinson:**

So I would say, probably I was thinking about this recently. I'd say the two models that resonate with me the most would be Pendleton's feedback model on the R2C2 model. Pendleton, I think, is where I first learned to give feedback. The idea is that you're really asking the learner to identify their own strengths and their own areas for improvement, and then offering constructive suggestions. The feedback should be quite balanced, so you're looking for both sides. It should be specific. So talking about concrete examples and what recently happened, and giving details to illustrate the feedback. It should be timely, so ideally, as soon as possible, to when the event happened, and it should be learner centered. I find that doing this in the moment with a trainee on the ward or in the clinic, and talking about a consult they just saw, or the day that we just had together overall, and asking them to do a lot of the reflection and the talking. Most learners are actually pretty aware of their strengths and weaknesses, and the more that you can sit back and just allow them to take ownership and talk about their experience, that tends to work the best. It also gives you a sense for whether they have insight into their strengths and weaknesses. I think the R2C2 model takes things a little bit further, and sort of puts that in the context of having set up a relationship where that feedback is going to be well received, and then also taking it forward to some coaching for performance change. So thinking about, okay, we've talked about these strengths and weaknesses, or, you know, challenges and opportunities, what are we going to do next in order to move your performance forward? When are we going to check in again? How are we going to make sure that this feedback is actually being implemented and is going to be useful for you?

**Heather MacNeill:**

And for those listeners who are coming on and might be like, what is the R2C2, or Pendletons? You know, certainly we'd encourage you to, you know, Google it or whatever. But we'll also have resources available on these models on our clinical faculty development website -- always great for me to pitch that out there. The R2C2 model is out of Dalhousie also. So if you Google Dalhousie and their faculty development unit with the R2C2 they have a lot of great resources explaining it with different feedback resources that you can use.

**Curtis Maloley:**

I love talking about feedback. I find feedback a fascinating topic, partly because the connotation of feedback can, at least for people getting feedback, can very frequently be negative. Like, when we say, like, I'd like to give you some feedback, someone you know has a natural reaction, like, "Uh-oh, this could be judgment." I wonder for you, Clare, like, when I was listening to you speak there, it sounds like the models that you're applying are very positive, and, you know, they're building the learner up, but feedback can be hard to receive. So how do you in your practice separate judgment from feedback, and how do you, how do you keep it motivating?

**Dr. Clare Hutchinson:**

It's interesting. I used to think that you had to say to a learner "okay, I'm going to give you some feedback now" so that they would know that this was the feedback conversation. But as you said, that can actually make it a bit more formal and intimidating and sort of put them in a place of feeling a bit of a deer in the headlights sometimes. So one approach that I have found helpful is to talk about it from the beginning and explain that feedback is going to be part of what we do, and it's expected that they're

going to be areas of performance that you're going to need help with. And that's actually exactly what I expect, and that's normal. So again, I'll give you an example. One of the weeks that I do every once in a while is on the newborn ward at North York General. And we're responsible for seeing all the newborn babies who are under pediatrics. So that could be 8 or 10 or 12 or 14 babies in a day. So it's a really nice chance to repeat a skill over and over. And if I'm working with a junior learner, usually, we'll start out the day, I'll sort of explain how things run, and I'll say, "Listen, okay, I'm going to send you in to go see this newborn. We've talked about what the exam consists of. It is my expectation that there's going to be parts of the exam that you're not going to be sure about, or you couldn't feel the femoral pulses, or you don't know if you heard a murmur, that's perfect. Then we're going to go back in together, and you're going to show me that piece of the exam that you weren't sure about, or you thought you found something abnormal, and I'm going to give you some tips and tricks on how to improve that." And so I don't necessarily say like "this will be feedback," but that's exactly what it is. It's watching someone's performance and coaching them for improvement. And I think setting the stage that I want you to come back to me and say there are things that you weren't sure about sort of gives them the space to be able to identify their weaknesses so that we can work towards improving. For me, that's like an easy win. And the students always come back to me with things they're not sure about, and they think they feel really open to do that. And then by the end of the day, I've had a chance to watch them do multiple skills, sometimes multiple times, and hopefully they've had a chance to improve and incorporate that feedback into the next baby they get to see, which is great.

**Heather MacNeill:**

I love that. Yeah, and, you know, I just love the practical aspects of what you're explaining there. One of the things that I find helpful too. You know, when you're at the medical student level, it's really hard to imagine what it's like to be the person on the other side interviewing, all you can really imagine is the terror and the anxiety you have being interviewed yourself. But sometimes when people have the opportunity to be on the other side and actually interview people, they think, "Oh, wow, yeah, now I get the perspectives of both sides," and I'm wondering your thoughts too around that as it relates to feedback. I know we're always encouraged to, you know, start off the conversation by asking the learner to give us feedback. But then I think, you know, there's, there is that hierarchy, and it's always, it's never really putting them in the shoes, I think, of being able to understand what it's like to give and receive feedback. And I wonder, can we be using learner to learner feedback a little bit to give them that perspective of that growth opportunity, especially as we're moving more towards these models like CBME, where we're really, you know, we're using feedback and coaching sometimes simultaneously. What are your thoughts on that?

**Dr. Clare Hutchinson:**

So it's interesting. You should bring this up. We just had a big conversation the undergraduate team who's putting together the curriculum at TMU about how receiving feedback and implementing it is a skill, but also giving good feedback is a skill, and the way that we're doing this Faculty Development Series to teach preceptors how to give timely, specific feedback based on observation and so on. Actually, medical students probably need to learn that from the beginning as well in order to allow them to give meaningful feedback, not only to facilitators and to the curriculum at large, but also to each other. So we've been talking about different models for how often should we do that? Should that be anonymous? Should it be done in like an open conversation? There's a lot of small group learning that

will happen in the curriculum at TMU, and we want to make sure that learners are given a safe space to provide that feedback, that they're given the tools to know how to do that in a respectful and professional and constructive manner. So there's actually a course at TMU called Personal and Professional Development, and part of that is about your growth and physician identity formation. And one of the early sessions will be about how to give and receive feedback and sharing a lot of the tools that we're talking about now, so that they can start building that skill from the very beginning to give good, useful feedback to their peers and facilitators, and then, you know, grow into a learner who's going to be able to receive that feedback, provide it to those around them, and ultimately as a staff person, to keep that sort of two way conversation going.

**Heather MacNeill:**

Sometimes I'll use that in the context of very beginner medical students, when they're learning how to do the history and physical, you know, on each other. Sometimes we'll start off just saying, "Okay, you're going to be the mock patient, but you have to give feedback to the learner after they've done, let's say the cranial nerve exam on you." And I feel like by engaging our learners in the feedback process, they're not only learning that skill, but it keeps their attention focused too, on what's going on. And I think, like, you know when we frame it as and I'm curious your opinion on this too. Like, I think. Sometimes people might take feedback so personally, especially, you know, new learners coming in that might be not used to the feedback process. How do we remove that from being a personal criticism to just a comment on their performance? What are your thoughts on that idea? Like, how do we change that perspective? Like, it's not about being a good or a bad person, but it's about the performance, and not even about good or bad performance, but what they perceived or got out of that performance.

**Dr. Clare Hutchinson:**

I think there's probably two things. I think one is sort of the broader culture that making it normal from day one, that feedback is meant to be a tool to help you improve and get to where you want to go to be that physician that you envision for yourself, and feedback is a crucial tool to help you get there, and it's going to be part of everything we do from the very beginning, getting constructive, or what we might have called negative, feedback, is not a bad thing. It's normal that at the beginning of a training process, there are things that need to improve and change. That's exactly where you should be, and in order to get to where you want to be, or need to be that feedback is going to be the thing that's going to help you get there. I think, also giving the medical students and the faculty the tools to give feedback in a helpful way. So like you said, we don't want to be commenting an overall judgment, of you're good, you're bad, you do poorly, you're lazy in small groups, you know, like things that are not actually helpful. But learning to comment on specific behaviors. "So I noticed when you listen to the lungs, you put your stethoscope here and not there, and that made me feel this way, or it might have been more helpful to do it another way." So commenting on a specific behavior that can be actioned and changed by the person, rather than on like an overall judgment, or commenting on something that they can't change about themselves. That's not gonna be very helpful. So I think giving people the skills to give correct feedback will also be a really important piece of that.

**Curtis Maloley:**

Oh, it's such a good, good point. You know, there's nothing worse than feedback that is not actionable. You know, when you get something that you can't, you don't know what to do with. You know, I'm

listening to you speak, and I'm wondering when you were, when you were a medical student, was feedback different then? Has it changed?

**Dr. Clare Hutchinson:**

Yeah, I definitely think it's changed. So I remember being a medical student and just sitting on the edge of my seat waiting for the end of the, you know, the midterm, or the end of rotation, and to get some feedback and know how I was doing. Like being such a little keener and just and feeling like I had no idea. I was in this sort of void of trying to have indirect references, like, "oh well, the faculty smiled when I presented my case. Did I do a good job? I'm not even sure." And then waiting for the sort of final feedback at the very end, and then you'd move off to the next rotation. So it wasn't the same culture that we have now, where feedback should be given on a frequent basis to help coach learners, improve the performance over time and repeat that skill. It was really much more of a sort of summative thing at the end of the rotation. You know, it all be revealed at the end, and you're sort of waiting for this final moment. I think things have really changed, partly related to Competency Based Medical Education and the idea that in order to help someone achieve competency, you can't just put them in environments and then wait till the end and tell them, did they do well or poorly. You really need to observe them and coach them along the way, and have these, you know, small adjustments to their performance that you're then getting the chance to reassess over time. That's really how you make feedback a useful tool for improvement. Waiting till the very end probably doesn't really help you all that much.

**Heather MacNeill:**

Can you give us an example of when you've given feedback to a learner in the past, and the outcome of that, you know, whether it be positive or negative? Do you have any examples that pop to your mind of when feedback went really well or when feedback was really challenging?

**Dr. Clare Hutchinson:**

So for me, I find the time that it goes the best and the time that I'm able to implement feedback the way I really want to is when I'm on that newborn week and I can give small pieces of feedback after having observed a learner perform a physical exam skill, like, for example, doing the Moro reflex on a newborn. I asked them to demonstrate for me how they do it. I can coach them on how I do it, or how they could place their hands differently. I asked them to repeat it in front of me, and then, you know, hopefully later on in the day, we'll do that again with another baby, and they'll have a chance to practice it and implement that feedback directly. And for me, that's kind of my, my best example of when it goes well. It's something that's very specific, it's very timely. I've observed them doing it, it's actionable, and we've set up a time to examine that again. So that's like my gold star way that I'm able to do feedback. Sometimes that's not always possible on a busy ward, if I have multiple emergency room consults and patients to see, I can't go into the room with the trainee every half hour and observe them doing a physical exam skill that's not realistic in a lot of contexts. And I think it's again, the same principle, though, of sort of micro-sampling and picking small pieces that you can observe a trainee doing. So you could ask them to do some discharge counseling on one medication that the patient's going home on, or explain one part of the diagnosis or repeat one physical exam maneuver. Doesn't mean you have to sit down and watch and do everything from start to finish. That's not going to be practical. No one has the time to do that. But picking these very small pieces that you can have them do, and ideally get in

the room and watch them. You know, I don't do that as much as I want to. There's the ideal, and then there's the practicality. And I think we have to aim for high and also be kind to ourselves and realize that we're also on a growth journey of becoming better and better at giving feedback in this model. I would say the times where it doesn't go well are when you haven't had the chance to go in and give frequent feedback, and then feedback that comes later in a rotation, comes as a surprise to someone that they're shocked to hear that their documentation of histories and physicals is not up to par, or that the way they speak to patients in medical jargon, you know, has not been helpful for a long time. Something like that, where they, for some reason, something has fallen through the cracks, and they haven't had that ongoing coaching. And then there's a more final moment towards the end, where they hear something that's a shock. And I think we really tried to move away from that, like you can't give someone bad news, let's say, about their performance without any other information coming before that. That should never really happen. That's something that probably happened to me more frequently earlier on in my career, where maybe it was more intimidating to give someone a small piece of constructive feedback over time, and I didn't know if I felt like I had the authority to do that, perhaps when I was a junior staff. And I think now that I'm more comfortable with it, you realize actually it's to your benefit to be able to help build someone up over time and improve their performance, rather than coming to the very end of something and giving them a shocking piece of bad news they weren't expecting. So that's what that would be my biggest advice. It's actually to everyone's benefit to address that from the beginning.

**Curtis Maloley:**

Oh, it's so interesting. I mean, it's interesting too, because, you know, earlier you were saying something along the lines of, like, the less I talk, the better. And so like, on the one hand, we're giving frequent and, you know, lots of feedback. And on the other hand, we want the learner to kind of take a lead in their own growth. How do you balance that?

**Dr. Clare Hutchinson:**

So I think when I was a junior staff, and I felt, "okay, I need to sit down and give people feedback." I felt like they wanted me to do a lot of talking and give them a lot of information, because that's how it was when I was a medical student or resident. You're sort of waiting for the judgment from your teachers, and then somewhere along the way, someone gave me some advice about just you don't really have to say that much, and really looking at, I think, like a Pendleton model of, if you can frame the question right and ask it in a way that makes people feel comfortable, you can hear a lot of what you want to know from the trainee. And actually, the nice thing is, not only do you get to hear their perspective, it also gives you insight about whether they are accurately judging where they are, if someone is really performing in a way that's not up to standard or not where they should be for their level of performance. And you ask them, How do you feel like things went today? And they're like, "Oh my God, it was amazing. I knocked it out of the park." You get some information about where they are judging themselves to be. And there's a bit of a gap there, but I would say 95% of the time when you sit down with a trainee, they're probably a little harder on themselves than you would be. I've just, you know, thought over the years about what are the questions that make it easy to answer? People don't respond necessarily as well if you say, "I'd like you to, you know, self-reflect and give yourself some feedback about your performance today." That's like a big, scary question. But I'll usually say something like, "What was one thing today that you were really proud of? What was one thing today that you want to

carry forward? If you could change one thing, what would it be? What would you want to do differently when we work together next week?" Just like a much smaller, more concrete question that will often, I only usually have to say one sentence, and they'll launch into a whole self reflection about what did go well, what they're hoping to improve on, what their learning goals are. Trainees are really now attuned to this, and they know where you're going with this conversation. They probably thought about it, and often you really don't have to say very much. You may validate what they're saying, give them some feedback, or, you know, point them in the right direction for different resources, let's say, about how they can improve, but most of the time, the less talking I do, the better and trainees, they're now on the same page as us. They know that this is how we want to operate. They're ready for that conversation for the most part. And I think giving them the floor also really empowers them to take ownership of their learning journey.

**Heather MacNeill:**

So I just want to thank you so much for your time today and all your insights. I love those questions that you know, what's one thing you learned and what do you want to work on next time? So really practical examples. So thanks for your time.

**Dr. Clare Hutchinson:**

Thank you for having me.

**Curtis Maloley:**

That was great and we also want to give a big thank you to our Teaching Resources and Technology specialist Sally Goldberg Powell, who produces DocTalks, as well as the Center for Excellence in Learning and Teaching at TMU for hosting this podcast.