Exploring Negative Feedback –
Is There a Positive Side?

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INTRODUCTION

We have all been there as practitioners in education. The moment when you have been reading many positive responses from students and a negative comment draws your attention and, although you have read many good things, this one stays with you and you keep on thinking about it (Psychologists call this the negativity bias). You have done your best in designing and delivering the programme and have other feedback that suggests that what you did worked well for the majority of students. Nevertheless, you look at the feedback in your hands and think 'but it didn't work for this one' and you ask yourself 'why not?' and think about what you could have done differently.

Feedback

The feedback in question came from an Interprofessional Education (IPE) session. The comments, from six students out of the hundreds who took part, all studying health and medical courses, stood out from all of the others. The IPE sessions had been running for the whole semester and from the cohort and discipline details on the evaluation forms, I could see that these students had been in a group that had attended most of them. The sessions had been on a range of issues, but each had involved group work with service users and small group work with students from other disciplines each led by a facilitator. Each of the seven sessions had been linked to flipped classroom work undertaken in advance of the face-to-face class. The flipped classroom focused on crosscutting themes such as professionalism and reflection. The feedback included a range of comments (Box 1).

Box 1: A sample of comments included in the feedback.

"I don't like working with patients and service users."
"I will learn about how to communicate with patients when I have to, but I don't feel that I want to do it now."
"I find it stressful talking to students from other disciplines."
"I do not like communication and working in small groups."
"I don't find patient stories interesting or engaging."

On the face of it, these are very worrying comments, coming as they do from students who are preparing to work in front line jobs within the NHS. It is particularly concerning when thinking about the work that the UK HE sector has put into 'values based recruitment' (Health Education England, 2016) following the Francis Report (Francis, 2013) which shaped the ways in which HE staff and partners in healthcare select students for programmes.

Whilst these were a minority of students (less than 1% of the overall cohort), it was still interesting to reflect on their coments as well as on the comments of practitioners from different disciplines within the NHS. One NHS practitioner commented: 'They can always go and work in theatre if they don't like patients' whilst another questioned: 'Is it a problem? I know a lot of colleagues who don't like patients', which didn't feel like a ringing endorsement of recent moves towards patient centred care (Department of Health, 2012; Health Education England, 2017).

Students' feedback statements are subject to the interpretation of the staff collating and evaluating them. It is interesting to trace the trajectory of this process. The initial response to the feedback comments was disappointment. This came from a place of feeling that if this is how, even a minority of students feel within their education programmes, then somehow we are failing to identify the right students for the programme or failing to give them the necessary insights into patient care. Undoubtedly, health tutors would prefer students to enjoy engaging with patients and service users and to be developing skills in this area given that engagement with patients is not optional and will always underpin the educational elements where relevant. However, much can be learned from these comments.

This feedback was authentic and honest. This is due in part to the flipped classroom work that encouraged reflection and professionalism. These students did not feel the need to provide comments which reflect the 'script', which is prescribed in identity formation as a health professional, i.e. that they enjoy working with patients (Goffman, 1956). Instead, they felt empowered sufficiently to feedback and make staff aware of what they felt about the educational experience. This is the first step in being able to address these issues. This reading of the feedback, accepts the 'reflection' and 'professionalism' elements of the course and may have, in some way, influenced the students' response given that the teaching within the flipped classroom encouraged and facilitated honesty and openness. Thus, a problem identified is a problem that can begin to be addressed.

Secondly is the question as to 'why?' they feel this way.

Interpretations could include students feeling unprepared to deal with service users and professionals from other disciplines. Alternatively it may be they lack the confidence to express themselves in groups, or need help to be able to actively empathise with others or develop attentive listening skills so that they 'hear' the deeper messages which lie behind patient stories. It could be a reflection on how service users tell their stories and a need to find ways to make these easier for learners to comprehend.

CONCLUSION

The experience demonstrates the need to ask not just questions of students, but the questions which will enable teachers to understand the diversity of issues and to acknowledge the tensions between different parts of the course i.e. 'I want you to be honest, but I would also prefer that you say that you feel x'. It also demonstrates the benefit in linking evaluation and feedback to personal development and having a joined up approach to addressing the crosscutting issues that students may identify.

Basic values and preferences are not a 'given' and space is needed to enable communication skills, empathy and compassion to grow. These are complex skills. We should anticipate that not everyone has them at the outset of a professional education and honesty in identifying the skills or values that are lacking is a good starting point to developing individualised student support.

REFERENCES

Department of Health, (2012). *Liberating the NHS: No decision about me without me.* London, UK: Department of Health. Retrieved from: https://bit.ly/2PpFyLz [Accessed 10/10/2018].

Francis, R. (2013). *Report of the Mid Staffordshire NHS Trust Public Inquiry.* London, UK: HMSO. Retrieved from: https://bit.ly/2L2WrZt [Accessed 10/10/2018].

Goffman, E. (1956). *The presentation of self in everyday life.* New York, NY: Random House.

Health Education England, (2016). V*alues based recruitment framework.* Leeds, UK: Health Education England. Retrieved from: https://bit.ly/2FlPFw9 [Accessed 10/10/2018].

Health Education England, (2017). *Person-centred care.* Leeds, UK: Health Education England. Retrieved from: https://bit.ly/2DnyfwR [Accessed 10/10/2018].

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The authors confirm being the sole contributors of this work and approved it for publication.

CONFLICT OF INTEREST STATEMENT

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