ORIGINAL ARTICLE

Quality of Clinical Feedback: Perceptions of Final Year BDS Students Versus their Supervisors

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ABSTRACT

Background: Clinical supervision can be defined as an activity in the clinical setting as a source of learning and assessment and problem solving for the student at an undergraduate or post graduate level.

Objective: This study aimed to see if various aspects of clinical feedback received by the students are perceived as the same by both students and supervising faculty.

Study Design: Cross-Sectional Study.

Place and Duration of Study: Islamic International Dental College, Islamabad, from January to June 2013.

Materials and Methods: An 18 item questionnaire was administered to former final year students and faculty which supervised them. The responses from each group were analysed and compared for differences in perception to the same measure of quality of clinical supervision and feedback.

Results: Items which involved communication were rated quite differently by the student and supervisor. Conflicting feedback was accepted by both, but supervisors thought that it was dealt with while students did not think so. Significance was set at a p value of 0.05

Conclusion: Exclusive availability of the supervisor and ability to see the task from the student's point of view by listening and taking time is very important. Supervisors cannot judge the quality of feedback they provide. They must receive feedback about the feedback they give.

Keywords: *Clinical feedback, Quality, Supervisors, Students.*

Introduction

"Clinical supervision" can be defined as a process of transferring knowledge and skills in the area where patient diagnosis and treatment takes place. It may also be used for assessment and practicing problem solving for the student at an undergraduate or post graduate level. It includes a procedure done by a learner and evaluated by a teacher who also gives meaningful feedback about the process to enhance the entire experience.[1]

Direct observation is essential to give feedback of an adequate standard, but this is not always possible. Attestations on quota sheets are often done without enough observation of the procedure while it was being performed.[2] The supervisor must exercise his best efforts to become a dedicated teacher, establish effective communication between patient, student clinician and himself, and also solve problems as they arise in a clear-headed way that is easily understood by the student. It demands tolerance and a willingness to take out enough time from a very busy clinical department. Students can be very critical about the instruction they receive. Karibe et al. reported that one fifth of Japanese dental students included in their study said the tutoring they received was not to their satisfaction.[3]

"Clinical feedback" is a composite of different parts such as overall quality, focus on detail, problem solving, coping with conflicts of opinion, the construction of new clinical knowledge upon that already possessed by the learner, how to present criticism without arousing negative feelings and stress in the learner, clarity of feedback, re-explaining if necessary and knowing the skills of the learner who requires feedback. A major challenge for dental educationists is to assess professionalism and clinical skills accurately.[4]

The objective of this study is to determine if the quality indicators of various aspects of clinical feedback are similarly perceived by students and supervisors and to see if some areas have greater difference of opinion than others.

Materials and Methods

A questionnaire was formulated according to currently held beliefs about the effectiveness and quality of clinical feedback. It consisted of 18 questions with five descriptive options each. One was drafted for students and the other having the

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same questions but drafted from a supervisor's point of view. For example in question 6 the student is asked if she can understand the feedback given. For the supervisor, this question would be if he felt that his feedback was understood by the student. Each question stem was followed by five options. Therefore, the questionnaires filled by the student reflected the evaluation of their supervisors' feedback while the questionnaires filled by the supervisors would be a form of self-evaluation.

All questionnaires were filled in anonymously. No coding system was used which meant that there would be no way to trace who said what at any stage of the study. In addition questionnaires were handed out after the result of the professional examination had been released so that answers could be given as honestly as possible without any fear of reprisal.

In final year BDS, according to the present PMDC curriculum, the clinical rotation lasts for approximately two months. During this time, the students are required to perform a variety of direct restorations using dental amalgam, composite resin and glass ionomer cement and endodontic treatments on patients. This was preceded in second and third year respectively by pre-clinical operative and endodontics to prepare the students for the clinical phase.

At the time of this study, clinical supervision was carried out by first and second year residents of the FCPS program as an adjunct to their time in the clinic. Some unofficial supervision would also have been provided by house officers during their three month rotation in the Operative Dentistry Department.

Data entry and analysis was done by SPSS version 17. Difference in results between students and clinical supervisors was analysed using the Mann-Whitney U test.

Results

Out of 95 former final year BDS students from two consecutive sessions, 71 returned the feedback forms. This gave a return rate of 74.7% for the students. Out of 12 supervisors, all returned their forms. This gave a return rate of 100%. Overall, this came to a return rate of 77.4%. Two reminders were given at an interval of one week each. Return of the form was considered as consent to use the information in the study.

All questionnaires were required to be returned anonymously with no coding system for retracing the person who filled the form. Names of the respondents were, however, ticked off as they received the forms, so that reminders could be given to those who had not yet returned the questionnaires. Demographics such as age, gender, income level and level of education were not noted as all students were in the same age group, income and educational level and were predominantly female. Questionnaires were filled by students after graduating from final year, during their house job so fear of consequences in the examination as a confounding factor was removed.

Discussion

Accurate self evaluation of clinical work leads to a competent dentist. According to this argument, accurate self evaluation of skills as a supervisor leads to better supervision in the dental clinic for the undergraduate students. This self evaluation was compared with the opinions of students. Since the aim of this study was to compare the perceptions of students and supervisors, no peer evaluation of individuals was done. The supervising faculty as a group was analyzed. Our study revealed many important similarities of perception of “quality indicators of clinical feedback” between students and supervisors but even more important and eye-opening were the differences.

Five questions out of 18 showed differences in opinion between students and faculty significant at a p value <0.001. These were amount of time without feedback (Q1), improvement of feedback skills of the faculty over time (Q5), if the supervisor asks when the feedback is not understood (Q12), re-explanation of the feedback if not understood (Q13) and receiving feedback by faculty behaving professionally without favoritism or grudges (Q15).

Three questions out of 18 showed differences in opinion between students and faculty significant at a p value of less than 0.01, i.e. at a confidence interval of more than 99%. These were understanding the feedback given (Q6), dealing with conflicting feedback (Q8), and characterization of criticism as constructive or destructive (Q11).

Three questions out of 18 showed differences in opinion between students and faculty significant at a p value of less than 0.05, i.e. at a confidence interval of more than 95%. These were seven questions out

Table I: Results from each question item showing the distribution of answers from students and supervisors (For explanation of a, b, c, d & e, see the appendix)

No	Question		a	b	c	d	e	variance	mean	significance
1	Amount of time you had to do without supervision or feedback	Student	2	8	23	36	2	.048	<.001	Yes
		Supervisor	0	4	8	0	0			
2	Has your personal dignity ever been compromised by the supervisor when requesting feedback	Student	20	17	26	7	1	.028	.055	No
		Supervisor	4	6	2	0	0			
3	Rate the overall proficiency of feedback given by those who supervised you in the Operative Department	Student	5	35	24	7	0	.016	.063	No
		Supervisor	2	9	0	1	0			
4	Are you comfortable with when requesting feedback	Student	2	13	23	17	16	.212	.021	Yes
		Supervisor	0	0	3	3	6			
5	Do you feel that your supervisors attempt to improve their feedback skills over time	Student	10	23	13	23	2	.026	<.001	Yes
		Supervisor	0	1	8	2	1			
6	Can you understand the feedback given to you	Student	2	4	24	30	11	.003	.001	Yes
		Supervisor	0	0	0	10	2			
7	How often have you received conflicting feedback	Student	4	10	44	16	0	.467	.853	No
		Supervisor	0	2	8	2	0			
8	How well does the supervising faculty deal with this conflict to your satisfaction	Student	2	27	33	19	1	.158	.005	Yes
		Supervisor	0	0	6	6	0			
9	When requesting feedback does the faculty make generalizations or focus on the problem you present	Student	3	18	30	18	2	.790	.013	Yes
		Supervisor	0	1	3	7	1			
10	Do you consider yourself a safe dentist as a result of the positive feedback you have received	Student	1	4	19	37	9	.029	.283	No
		Supervisor	0	1	0	10	1			
11	The criticism you received was constructive or destructive	Student	0	3	30	34	4	<.001	.006	Yes
		Supervisor	0	0	1	10	1			
12	Do your supervisors ask if they feel you have not understood the feedback they gave	Student	8	14	34	12	3	.410	<.001	Yes
		Supervisor	0	0	1	5	6			
13	If you have not understood, does your supervisor attempt to reexplain in another way	Student	4	11	35	13	8	.832	<.001	Yes
		Supervisor	0	1	1	2	8			
14	Have you ever shown disrespect towards the faculty member giving you feedback	Student	46	31	3	1	1	.322	.836	No
		Supervisor	5	7	0	0	0			
15	Do you receive feedback in a professional manner without favouritism and personal grudges	Student	1	13	23	19	26	<.001	<.001	Yes
		Supervisor	0	0	0	3	9			
16	Is the environment conducive to acquiring the correct clinical skills due to the accurate and timely feedback you have received	Student	4	22	28	16	1	.858	.019	Yes
		Supervisor	0	2	3	6	1			
17	Does your supervisor start by asking you for your assessment of the clinical situation	Student	2	15	37	14	3	.237	.131	No
		Supervisor	0	3	1	8	0			
18	How well does the supervising faculty know about your strengths and weaknesses as a clinician	Student	13	30	24	2	2	.159	.098	No
		Supervisor	0	4	7	1	0			

of 18 showed opinions of students and faculty which were not statistically significant (p value > 0.05). These were compromise in personal dignity when receiving feedback(Q2), overall proficiency of feedback(Q3), receiving conflicting feedback(Q7), consideration of oneself as a safe dentist as a result of positive feedback received(Q10), showing disrespect towards the supervisor(Q14).

When asked whether the student was comfortable while requesting feedback, 33/71 replied in the negative. This may not only be because of a personal shyness or a fear of negative behavior on the part of the supervisor but also because the supervisor has his own duties with patient care and may not be free at that particular point of time. Thus the student hesitates to ask the supervisor for feedback in the interest of the patient being treated.[5] This raises the ethical question of number of faculty members required to deal with educational and patient needs. World over, there is a shortage of dental faculty due to greater earning as a private practitioner.

Human qualities such as respect and integrity are often differently assessed between different groups of critics.[6] In our study, we found that the respect for students was similarly perceived by students and faculty while there was a statistically significant difference between the perceptions of respect given by the faculty to students. This is may be partly due to the fact that the students are under stress because of academic and quota requirements and have needs in excess of the normal everyday interaction.

It is interesting to note that all categories of question stem which require communication skills, especially listening came out as significantly different between supervisor and student. Questions 5, 6, 12 & 13 were all significant with students claiming that supervisors were not doing enough. Clarifying conflicting feedback, giving specific feedback, giving feedback that can be understood, and asking when the student seems not to be understanding were all cited by students as inadequately performed and by supervisors as adequately performed. Positive reinforcement and hearing the students views instead of instructing and speaking has been perceived as a better method of clinical supervision.[7]

Strengths of our study include the anonymity of the questionnaire and the fact that the students questioned had passed the Final Professional examination and would have had no fear of repercussions. Therefore more honest opinions would be expected and reporting of negative experiences towards the supervision would be not be lessened.

Weaknesses include a relatively small sample size. Further intervention is required by training faculty acting as clinical supervisor to see if any of these perceptions come closer together.

Conclusion

Supervisors may think they are doing a good job but students may not be satisfied about every aspect of the feedback they receive. Training for clinical supervision duties should be made mandatory. Supervisors should be more attentive and empathetic towards the students being supervised. Time devoted to supervision and focus of concentration on the problem at hand should be improved. The PMDC should have a mandatory requirement of faculty in the clinic exclusively to supervise in order to increase availability of the supervisor.

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