Listen up! Tips for giving effective feedback

**Feedback is value neutral?**
Exactly. Evaluation means to place value on a performance or piece of work. Feedback is value neutral. It describes what you did or did not accomplish, given a standard or expectation.

**What is the best way to measure feedback?**
It cannot be derived from tests, exercises, or simulations. The activity being assessed is your everyday “real-life” work.

**What do you see as the purpose for feedback?**
We can’t expect improved performance if the learner does not know what he/she needs to change. Unless feedback is given, how does the learner know what they do well so they can continue doing it? Most people really want to know how they are doing and if their teachers (or the people they report to) like what they’re doing. They also want to know if something could be done more effectively.

**Why is feedback so important in health care and medical education?**
Feedback is central to medical education in promoting learning and ensuring that standards are being met. It provides the learner (student, resident, staff or other health care provider) with an accurate perception of their own performance and provides enhanced self-awareness.

**What rules do you aspire to?**
Brown & Leigh’s Feedback Rules (1996) offers a good list. Feedback should be timely, given as close to the event as possible (taking account of the person’s readiness). It should be selective, addressing one or two key issues rather than too many at once, and balanced, addressing both the good and bad. You should offer suggestions rather than prescriptions. Feedback constraints play a role as well. There are many people that may have poor feedback skills or are unaware of the importance of feedback. In a teaching environment, for instance, you have to know about your student’s performance. Limited knowledge about performance will result in bad feedback.

On the receiving end, there’s always the danger that feedback may be perceived as personal judgment. Inconsistent messages can also confuse the learner. Other factors, like an inappropriate environment during delivery of feedback, or the learner’s own differing goals, may also get in the way.

**What outcomes should you look for when giving feedback?**
It’s important to remember that feedback is not an end in itself. It shouldn’t be used as a solution to performance problems, for praise or blame, approval or disapproval.

**What are some of the challenges that currently exist for giving and receiving good feedback?**
There may be several obstacles. For one, it can be uncomfortable giving negative feedback. There are also concerns about consequences of negative feedback.
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should be descriptive, specific (or focused), and directed.

Can you give an example of descriptive feedback?

It should be non-judgemental, based on behavior not personality. For example:

“I notice that you don’t look at patients when they are talking to you.”

And can you elaborate on directed feedback?

Feedback should be directed towards behavior that can be changed. Before you give feedback, ask yourself: What is my intention behind giving this person feedback? How am I feeling about giving it? How is the other person feeling? I think it’s also important that both people should feel calm during the process (i.e., waiting to provide feedback if there has been an acute emotionally-charged situation).

Can you give a few examples of how this works in practice?

Set the stage by telling the learner from the outset that you will give feedback throughout the learning process (rotation, residency, training period). It should be structured, not casual. Engage the learner in the process of self-assessment. Ensure privacy and allow adequate time for discussion. Ask the learner to assess their own performance first. This begins a conversation — an interactive process — and allows you to assess the learner’s level of insight and stage of learning.

Pay attention to your tone of voice and body language. Make sure your nonverbal cues match what you are saying to the student. Remember that the feedback you give is your perception and not the ultimate truth. To reflect this, use phrases such as “I noticed” instead of “You did.” You might say, “I find your actions” instead of “you are,” and “I feel” instead of “you didn’t.”

Are there multiple impacts of feedback?

Yes. Unfortunately the person receiving the feedback can react with anger, denial, blame, or rationalization. But when it’s effective, the impact can be acceptance and renewed action.

Do you then suggest rules for receiving feedback?

I tell my students and residents to listen carefully to what is being said. People should be receptive to feedback and see it as helpful. Again, acceptance is a big factor. Accept positive feedback, don’t reject it. Accept negative feedback, don’t reject it. And avoid arguing or being defensive. The learner should also be encouraged to ask questions, clarifying and seeking examples as appropriate. Although it can be difficult, it is important to acknowledge the giver of feedback and show your appreciation. Feedback is not always easy to give. The feedback process should involve mutual goodwill; the learner should feel that the giver is on the same team, and the giver needs to want to help the learner develop.

What should the learner or recipient do with the feedback?

Ultimately it is up to the recipient. I suggest they keep notes, give it time to sink in, and put it into perspective. Mutually, the person giving and the person receiving feedback should address areas for improvement and develop an action plan.

Can you provide a few more examples of the feedback process in practice?

I like the “ask, tell, ask” model. For example, ask the learner about their goals, i.e., “What are/ were your goals for this rotation?” and ask the learner for self-assessment. “How do you think it went?” “What did you do well?” “What could be improved?” Then tell what you observed, your diagnosis, and explanation.

React to the learner’s observation, including both positive and corrective elements. “I observed . . . .” for example. Give reasons in the context of well-defined shared goals. Then return to asking. Ask about the recipient’s understanding and strategies for improvement. “What could you do differently?” Ask again about their own goals. “Have your goals changed?” And then return to telling. “This is my suggestion . . . .” But commit to monitoring the improvement together.

So where do you even begin to develop these types of skills? The Academy’s Leadership Institute is a great resource for young dermatologists looking to develop and improve their leadership skills; it includes training and mentoring programs, and networking events. The Leadership Institute also offers sessions at Annual and Summer Academy meetings. To learn more about the Academy’s Leadership Institute offerings, visit www.aad.org/Leadership.

Suggested reading:


Roopal V. Kundu, MD, is an associate professor of dermatology and residency program director at Northwestern Medicine in Chicago.
A doctor loan is a specialized home loan financing program for medical doctors, including residents and fellows, looking to purchase or refinance their primary residence. In most cases, only a minimal down payment is necessary (if at all). Private Mortgage Insurance (PMI) is not required, and a range of fixed and adjustable rate loans are available.

The physician or doctor loan

In general, a physician loan or doctor mortgage is a portfolio loan product. This means that the bank or institution that is making the loan is actually going to keep and service the loan. This enables the bank making and servicing the loan to determine its own underwriting guidelines and risk threshold, resulting in more liberal guidelines for physicians. However, each bank’s guidelines are different, so you may not qualify for one but may be a perfect match for another. For this reason, it is best to work with a loan officer that specializes in working with physicians and other health care professionals. As a result, he or she will be much more likely to understand your unique situation and circumstance and help you choose the loan that is right for you.

The following are several benefits of getting a physician home loan over a conventional loan:

Higher chance of approval: When some “outside of the box” factor makes you ineligible for conventional financing, a physician home loan might be your only option. Often residents, fellows, and new-to-practice physicians are declined for conventional loans because they just don’t fit the guidelines due to student loans, time on the job, and/or the amount of down payment required.

Low down payment: The physician home loan will finance 90 to 100 percent loan to value depending on the bank making the loan, where the property is located, and the loan amount you are seeking.

No private mortgage insurance (PMI) required: Most lenders feel that borrowers who make low down payments (and therefore have little equity in the property) are more likely to default on a mortgage loan. As a result, they generally require you to purchase private mortgage insurance if you are borrowing more than 80 percent of the value of the home you are purchasing (your down payment is less than 20 percent of the purchase price). PMI ensures that your lender will be paid if you default on the mortgage. With a physician home loan, you do not have to pay mortgage insurance even if you finance greater than 80 percent of the purchase price.

Typically, the doctor mortgage is going to save you 0.5 to 1 percent in annual PMI, but you will pay 0.25 to 0.5 percent higher rate for this loan type.

Student loan(s) are not counted against your debt to income ratio: This is a significant difference between a physician home loan and a conventional loan, particularly for someone transitioning out of residency or fellowship where student loans might be deferred or in Income Based Repayment. Conventional underwriting guidelines do not allow you to exclude payments for any deferred, income based, or loans in forbearance. In any case, where the current payment is zero, conventional guidelines require underwriting to count that debt against your monthly debt to income ratio at 2 percent of the outstanding balance. Physician home loans will typically allow you to exclude or use an IBR payment to qualify, thus resulting in a higher loan amount.

Higher loan limits: Since physician home loan lenders do not sell the loans to Fannie Mae and Freddie Mac, they are not going to have the conventional loan limits. The loan limits will vary by the location of your new home and by the institution that is making the physician loan. Generally, you will be able to borrow a higher amount with less money down using a doctor loan than you could under a conventional loan.

Ability to close before starting work: Most conventional mortgage lenders will require that you provide two paystubs before you close on your new home. A physician home loan will allow you to close prior to starting work.

Flexibility in terms of proof of income: Conventional underwriting guidelines typically require two years worth of tax returns for proof of income if you are self-employed or an independent contractor (paid on a 1099 and not a W-2). This situation is very common for dermatologists and, as such, these physicians may have to wait until they have two full years tax returns, which is often nearly three years on the job before they can obtain conventional financing. A physician home loan will allow a self-employed

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There are a number of reasons for dermatologists to focus on improved management of melanoma. The rising incidence of melanoma, certain subtypes that are more challenging to diagnose, and the increased morbidity and mortality that result from misdiagnosis have significant implications for melanoma patient care and outcomes.

Liability is an issue that must also be considered. Between 1985 and 2008, 2,704 medical professional liability claims against dermatologists were closed. Error in diagnosis of melanoma was the second most common allegation, and 42.2 percent of these claims were paid with an average payment of $436,843.1

No dermatologist plans to miss a melanoma diagnosis, but careful review of cases in which the diagnosis was missed or delayed provides insight into specific strategies that can reduce the risk of misdiagnosis.

The following are seven common scenarios of melanoma misdiagnosis:

1. Misdiagnosis of nodular melanoma as a benign lesion by a clinician.
2. Misdiagnosis of nodular/nevoid melanoma as a nevus by a pathologist.
3. Incomplete or partial biopsy leading to an inaccurate diagnosis.
4. Melanoma misdiagnosed as a dysplastic nevus involving margins.
5. Melanoma misdiagnosed as Spitz nevus.
6. Unrecognized desmoplastic melanoma.
7. Patients presenting with metastatic disease with an unknown primary: Consider biopsy of any unusual regrowth at sites of destruction.

Nodular and nevoid melanomas, desmoplastic melanomas, and melanomas with spitzoid features are challenging subtypes to diagnose; however, focusing on proper biopsy techniques for a lesion suspicious of melanoma can help dermatologists to make an accurate diagnosis.

Of 23 melanoma claims filed between 1998 and 2001, 83 percent involved incomplete removal of the pigmented lesion for biopsy by shave technique, punch biopsy, or other incisional biopsy.3 This underscores the need to carefully plan the excisional biopsy if there is suspicion of melanoma. The ideal biopsy of a potential melanoma encompasses 1 to 3 mm margins of adjacent normal skin. This margin increases the accuracy and specificity of the dermatopathologist’s diagnosis.

Curettage should not be used to biopsy pigmented lesions because the technique does not allow for adequate measurement of the depth of invasion or assessment of the entire lesion, which can affect therapeutic plans. In addition, if unusual regrowth occurs at any biopsy site, dermatologists should strongly consider a repeat biopsy or excision to rule out melanoma.

Another way to avoid melanoma misdiagnosis is to ensure correct labeling and submission of the specimen at the time of biopsy. Time outs can be taken before any biopsy. Verbally identifying the site before performing the procedure and verifying that accompanying photos and specimen labels match the site are essential for an accurate diagnosis. This process reduces the risk of a pathologist mistakenly switching diagnoses for the two sites, leading to mistreatment of a benign lesion and could delay diagnosis and treatment of melanoma.

A few clinical pearls

- Be thoughtful about your biopsy — use excisional biopsies for lesions highly suspicious for melanoma, obtain adequate margins, and label specimens correctly.
- Every biopsy site should be monitored. Re-biopsy or re-excision should be considered for any unusual regrowth.
- Explain the ugly duckling concept to patients. For “moley” patients, review the concept of signature nevus to help find “ugly ducklings” for self-skin screening.
- Have open communication with patients and be available to answer questions for any patient with a new diagnosis of melanoma.

Caroline C. Kim, MD, is director of the Pigmented Lesion Clinic and associate director of the Cutaneous Oncology Program, department of dermatology, Beth Israel Deaconess Medical Center.
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physician to qualify with as little as a six-month history of income, enabling you to buy a home almost two years earlier with a physician loan than you could with a conventional loan.

Mortgage types

The two most common types of mortgages are fixed rate mortgages and adjustable rate mortgages (ARMs). Fixed rate mortgages feature equal monthly installments over the term of the life of the loan. The most common fixed rate mortgages have terms of 15 or 30 years.

ARMs offer reduced initial interest rates, typically fixed for a specified time period, followed by an adjustable period where the rate floats with the market. These types of mortgages are often identified by their rate adjustment periods. For example, a 7/1 ARM offers a fixed interest rate for the first seven years and an annually adjusted rate for the duration of the loan. Since the term of your mortgage remains constant, the amount necessary to pay off your loan by the end of the term changes as your loan’s interest rate changes. Thus, your monthly payment amount is recalculated after the initial seven-year fixed period.

Most ARMs specify interest rate caps. The periodic adjustment cap may limit the amount of rate change, up or down, allowed at any single adjustment period. A lifetime cap may indicate that the interest rate may not go any higher (or lower) than a specified percentage compared to the initial interest rate.

ARMs can be a valuable resource for physicians who plan to relocate and sell within the initial fixed rate period, as the initial fixed interest rate is often considerably lower compared to the rates on either a 15- or 30-year fixed rate mortgage. For this reason, it is important that young physicians seriously consider the length of time that they plan to remain in their first home.

Summary

Physicians, especially those early in their careers, have rapidly increasing incomes, fluctuating student loan liabilities, and need for specialized home loan products that allow for more liberal qualifying guidelines. Physician home loans allow for more flexibility in underwriting as well as principle reduction and re-amortization of mortgage payments once in the home. There are several mortgage programs that will allow you to make big principle reductions, which allow for both lower mortgage interest rates and lower minimum monthly payments without refinancing. For these reasons, a doctor loan may be something to strongly consider.
GET INVOLVED WITH THE ACADEMY’S NEW MENTORSHIP PROGRAM

Think back to that first year of dermatology residency, or maybe all of residency. It's likely that feelings of stress come to mind. With the Academy’s new and expanded Mentorship Program, you can share the wisdom you’ve gained throughout your career with residents and other early-career dermatologists. Maybe you had a mentor who was essential to your career growth. Or maybe you can imagine how invaluable the advice of a mentor could have been.

Mentorship is an important element of a successful career in any field. Physicians who have had mentors report having more career satisfaction and believe that these relationships have positively affected their job satisfaction and promotions in their field. Many dermatology training programs have begun to emphasize mentorship programs, which have resulted in a high degree of resident satisfaction.

Be a mentor!

Becoming a mentor through the Academy has never been easier. Browse Academy programs and opportunities at www.aad.org/MentorOpportunities. Once you’ve identified areas of interest, fill out a mentorship profile at www.aad.org/mentorship/profile. Filling out a profile will allow your information to be shared with potential mentees to match interests using the Academy’s new searchable mentor database, www.aad.org/mentorship/search.

No matter what skills and advice you have to offer, the Academy’s expanded database will connect you with a mentee who seeks your specific skill set.

Reference

1 Caroline C. Kim, MD, Ellen J. Kim, MD, Clara Curiel-Lewandrowski, MD, Victor Marks, MD, Mary Maloney, MD, Ilona J. Frieden, MD, A Mentorship Model in Dermatology. JAAD 2011.

LET YOUR CAPILLUS DOWN AT THE YOUNG PHYSICIAN/NEW MEMBER RECEPTION!

For all young physicians and new Academy members attending the 72nd Annual Meeting, don’t miss the Young Physician/New Member Reception on Friday, March 21 at 5 p.m. The reception will take place in Centennial F at the Hyatt Regency.

At this year’s reception, you'll network and socialize with other young physicians and new members from across the country. In addition, you will be able to chat with Academy leadership and staff. And if you’re easily swayed by food and drink, there will be plenty for all! The reception will also have information about how you can take advantage of AAD resources and get involved in AAD programs.

The Academy offers a wealth of resources, and the Young Physician/New Member Reception is the perfect place to learn about them as well as how to get involved in other Academy programs, such as volunteer opportunities, the mentorship program, Leadership Institute, and lots more. There's also likely to be an AAD photographer at the event snapping candid shots, so you know it’s an event not to miss! See you at Centennial F!

YOUR COMPLETE YOUNG PHYSICIAN SURVIVAL TRAINING AWAIT S YOU IN DENVER

The first 10 years of practice bring unique challenges. The best opportunity to learn about these challenges and how to address them is by attending “Young Physician Pearls and Pitfalls: A Survival Guide for the First 10 Years,” being presented Sunday, March 23, 3:30 to 5:30 p.m. in the Mile High Ballroom at the Colorado Convention Center in Denver during the AAD Annual Meeting.

A young physician’s challenges are ever-changing. It’s not only important to keep up with new medical advances, but also to be able to run and market your practice, use new technologies and social media, and comply with all new regulations. Many young physicians also desire to give back and continue to advance the specialty. Led by session director Gary Goldenberg, MD, and co-director Caroline C. Kim, MD, (and including several noted guest speakers) this session will give young physicians the tools needed to continue to be successful, including marketing, EHR, coding, mentoring, and lessons learned by other young physicians.

At press time, the slate of speakers and topics include:

• Daniel M. Siegel, MD, MS: Top Coding Mistakes Young Physicians Make
• Dr. Goldenberg: 10 Common Questions Patients Ask
• Dr. Kim: Mentorship Opportunities for the Young Physician
• David M. Pariser, MD: Supervision of Physician Extenders
• Seemal R. Desai, MD: Pearls from the First Years of Practice
• Wendy Lewis: Practice Marketing: Social Media and the Internet
• Mark D. Kaufmann, MD: Electronic Health Records Update

This session offers 2 Category 1 CME Credits.
WE HEAR YOU LOUD AND CLEAR!

Thank you to those of you who responded to the young physician survey distributed in late 2013. Your responses provided valuable insight into your perspectives on what the Academy can and should be doing for you. From your comments, it is clear that young physicians want to be actively engaged in the Academy, and it’s the job of the Young Physicians Committee (YPC) to ensure that you know what Academy opportunities are available. The YPC will use the survey data to guide future programs and communications. It is also clear that practice management issues are on the forefront of many of your minds. With that in mind, I am pleased to announce that a section dedicated to practice and professional management issues will be part of YP Focus starting with the next publication. Please send me your topic suggestions and questions that can be used to generate content for this important subject.

Submit a Focus session

The AAD Scientific Assembly Committee (SAC) plans, implements, and evaluates AAD educational sessions; these are the folks that decide whether your submission to present at an Academy meeting is accepted or not. They’ve recently made some important changes to the format of Focus sessions for future summer and annual meetings. In the past, Focus sessions were slated for 1.5 hours with a single presenter. The SAC has determined that going forward Focus sessions will allow for a maximum of 2 presenters, a change which should increase the number of participating speakers, including young physicians, and will also enhance the educational offerings at meetings. So pair up with a fellow young physician and submit an application for a session at www.aad.org/faculty/am2015/application. The submission deadline for the 2015 Annual Meeting is April 8, 2014.

I hope to see many of you at Annual Meeting in Denver! 😊

Your future, your vote

As members of the Academy, it is our duty to guide the future of the organization through democratic election of Academy leadership. The Academy election opens March 22, and voting will close on April 21. In 2013, 28 percent of eligible young physician members voted in the AAD election, the highest rate of voting since 2008. While young physicians comprise 21 percent of membership, we only represented 17.6 percent of the voting population in the 2013 election. I believe that we can and will do better this year. For more information on this year’s slate of candidates, go to www.aad.org/AADelection. This year there is a new virtual town hall where members can submit questions to candidates and view answers. The candidates will also be attending the Young Physician/New Member Reception at Annual meeting on Friday, March 21, 2014. The Academy has made it easier than ever to vote online. Just do it!

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