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Editorial

From Silence to Voice: Making Upward Feedback the Norm in Medical Trainings

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"The single biggest problem in communication is the illusion that it has taken place."

George Bernard Shaw

In medical education, feedback has traditionally been a one-way process: from teacher to learner. Supervisors assess and trainees receive. This top-down model is reflected in our systems and cultures, mirroring the hierarchical frameworks that define healthcare organisations. However, a growing body of evidence[1-5] — and plain common sense — obliges us to reconsider this model. If we are serious about lifelong learning, professional responsibility, and safer patient care, feedback must become a two-way process. The concept of 'upward feedback', whereby trainees provide feedback on their supervisors in a formalised and protected manner, offers a promising approach to updating our understanding of supervision[5-7]. As outlined in the recent review published in the Acta Anestesiologica Belgica, 'Upward Feedback in Anesthesiology Training: From Theory to Practice'[8], upward feedback is presented as a cultural intervention, not just a teaching tool. And it is both necessary and unsettling.

Why does it matter?

When done well, upward feedback can be transformative. It promotes a culture of reflection among faculty members, improves the quality of education, and fosters mutual respect[9]. Most importantly, it improves the psychological safety of both medical learners and educators — a critical condition for meaningful learning, collaboration, and well-being. Studies have shown that residents who perceive their supervisors as supportive experience less burnout, and that improved supervision is linked to fewer clinical errors. Furthermore, teaching is not an innate skill; it is a skill that can be learned and refined throughout one's career[10]. Without feedback, it is difficult to refine teaching skills[10,11].

Moreover, the review[8] suggests that upward feedback could destabilise the hidden curriculum – the secret, and often poisonous, lessons that students learn about power, silence, and fear. If feedback only flows in one direction, we inadvertently teach that power means never being criticized. That learning is something to be extracted from teachers rather than modelled by students. Upward feedback disrupts this asymmetry. It affirms that supervisors are not exempt from development and that trainees have a voice.

As physicians, we are lifelong learners, whether we are working on the wards, in the clinic, or in the operating theatre as anaesthetists[12]. We promote this philosophy when mentoring medical students and residents, encouraging them to cultivate curiosity and a sense of humility. However, we often encounter resistance when it comes to receiving feedback from those in more junior roles.

Why is it still so difficult to accept upward feedback?

Despite its usefulness, upward feedback is rarely used and is practised inconsistently, even in clinical education. The Belgian context presented in the review illustrates this gap perfectly. While neighboring countries, such as the Netherlands, have extensively adopted tools like SETQ[13], there has been no systematic application in Belgian postgraduate anaesthesia education, as well as within other programs in Europe — until now.

This inertia is predictable. Changing the culture of feedback in medicine means confronting deeply rooted traditions, structural hierarchies, and personal insecurities. Trainees are reluctant to provide honest feedback for fear of reprisals, damaging relationships or being rebuffed[14]. Supervisors, for their part, are likely to be defensive or sceptical about the relevance of the feedback, or too busy to engage with it constructively.

The halo effect[15], whereby a trainee's overall impression influences their entire evaluation, only compounds the challenge. Anonymity can be beneficial, but it also carries its own risks. If not carefully phrased, anonymous comments can become vague or cruel, while identifiable ones may be sugar-coated or censored. In short, providing feedback is a risky social act in medicine, and it appears even more dangerous when it is given by subordinates to superiors.

Making the Theory Work: Lessons from Practice

The interesting aspect of the Belgian application described in the review[8] is not the idea of upward feedback itself, but rather how the team responded to it. Rather than simply adopting a tool from another system, they adapted it to their own needs. They translated De Oliveira's questionnaire[16] into Dutch and added locally applicable questions (e.g. whether the supervisor is a good role model). They then embedded the questionnaire in Medbook (Imengine bv, Leuven, Belgium), a system already used by supervisors and trainees. This reduced the administrative workload and made continued use more probable.

Notably, they introduced the system in phases, beginning with a 'silent' baseline period during which the supervisors were unaware that they were being evaluated. Supervisors were only notified after this baseline data had been collected, and were then given their feedback in a structured, anonymized, and peer-comparative format. This allowed for open input and reflective consideration, free of immediate defensiveness.

Implementation: more art than science

The authors also anticipated a fundamental issue that most upward feedback systems overlook: culture. In Belgian culture, as in many others, open criticism, particularly from junior to senior staff, is socially frowned upon. Recognising this, the team designed their system to work with, rather than against, the local culture. Anonymity, representative spokespeople, and depersonalised group feedback were all strategies designed to ease social discomfort while ensuring the feedback remained meaningful[5,11,17].

However, culture is only half the problem. The other half is time pressure. Managers, who are often juggling clinical, administrative, and academic duties, may lack the capacity to interpret or act on feedback, even when they value it. To address this issue, the Belgian team integrated the feedback process into regular performance review meetings and prioritised the use of Personal Development Plans (PDPs). Making feedback actionable requires integrating it into the workflow, rather than adding it as another task.

Notably, both trainees and supervisors received dedicated training in feedback skills—a step that is often neglected. We often assume that doctors naturally know how to give and receive feedback. They don't. Feedback is a skill, and without intentional learning and practice, even the best-designed systems can falter[3,5,17].

Most critically, this paper highlights that implementation alone is insufficient. For upward feedback to be effective, it must become normalised. Feedback must feel like an integral part of professional life, not a one-off survey. Medical training must evolve towards a culture of feedback, not just a feedback form — a culture in which supervisors expect, welcome, and respond to feedback, and in which trainees are not only permitted to speak up, but also equipped to do so thoughtfully and constructively[5-7].

Finally, we must resist the temptation to measure success solely through survey scores or participation rates. The real indicators are whether meaningful conversations are happening, whether behaviours are changing, and whether the learning environment feels safer, more collaborative, and more responsive for everyone.

Conclusion: The moral imperative of listening

In a profession where lives depend on continuous improvement, failing to establish feedback channels from the outset is not just an educational oversight — it is a moral one. When trainees are silenced, supervision stagnates. When supervisors are insulated from criticism, their professional growth stalls. When learning becomes one-way, it becomes brittle.

The Belgian initiative offers a roadmap. It is intentional and thoughtful. It starts small but has much larger ambitions. Rather than treating upward feedback as a mere tick-box exercise, it recognises its potential to drive cultural change.

This is what the future of medical education demands.

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References

1. Ramani S, Krackov SK. Twelve tips for giving feedback effectively in the clinical environment. Med Teach. 2012;34(10):787-91.
2. Ramani S, Post SE, Könings K, Mann K, Katz JT, van der Vleuten C. "It's Just Not the Culture": A Qualitative Study Exploring Residents' Perceptions of the Impact of Institutional Culture on Feedback. Teaching and Learning in Medicine. 2017;29(2):153-61.
3. Ramani S, Leinster S. AMEE Guide no. 34: Teaching in the clinical environment. Med Teach. 2008;30(4):347-64.
4. Young JQ, Sugarman R, Schwartz J, O'Sullivan PS. Overcoming the Challenges of Direct Observation and Feedback Programs: A Qualitative Exploration of Resident and Faculty Experiences. Teaching and Learning in Medicine. 2020;32(5):541-51.
5. Boud D, Molloy. Feedback in Higher and Professional Education. London: Routledge; 2013.
6. van Dierendonck D, Haynes C, Borrill C, Stride C. Effects of upward feedback on leadership behaviour toward subordinates. Journal of Management Development. 2007;26(3):228-38.
7. Wisener K, Hart K, Driessen E, Cuncic C, Veerapen K, Eva K. Upward feedback: exploring learner perspectives on giving feedback to their teachers. Perspectives on Medical Education. 2023;2(1):99.
8. Maere MD, Baerdemaeker LD, Moerman A. Upward feedback in anesthesiology training: from theory to practice. Acta Anaesthesiologica Belgica. 2025.
9. Boerboom TB, Stalmeijer RE, Dolmans DH, Jaarsma DA. How feedback can foster professional growth of teachers in the clinical workplace: A review of the literature. Studies in Educational Evaluation. 2015;46:47-52.
10. Aitken G, Fawns T, Warran K, Jones D. Making space to learn about teaching: expanding teaching horizons through postgraduate education. Adv Health Sci Educ Theory Pract. 2023;28(2):327-44.
11. Weiner SG, Totten VY, Jacquet GA, Douglass K, Birnbaumer DM, Promes SB, et al. Effective teaching and feedback skills for international emergency medicine "train the trainers" programs. J Emerg Med. 2013;45(5):718-25.
12. Berger-Estilita J, Krista L, Gogollari A, Schmitz F, Elfering A, Guttormsen S. Self-directed learning in health professions: A mixed-methods systematic review of the literature. PLoS One. 2025;20(5):e0320530.
13. Lombarts MJ, Arah OA, Busch OR, Heineman MJ. [Using the SETQ system to evaluate and improve teaching qualities of clinical teachers]. Ned Tijdschr Geneeskd. 2010;154:A1222.
14. Zhou AY, Baker P. Confounding factors in using upward feedback to assess the quality of medical training: a systematic review. J Educ Eval Health Prof. 2014;11:17.
15. Thorndike EL. A constant error in psychological ratings. Journal of applied psychology. 1920;4(1):25-9.
16. de Oliveira Filho GR, Dal Mago AJ, Garcia JH, Goldschmidt R. An instrument designed for faculty supervision evaluation by anesthesia residents and its psychometric properties. Anesth Analg. 2008;107(4):1316-22.
17. Ende J. Feedback in clinical medical education. JAMA. 1983;250(6):777-81.

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