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## TITLE PAGE

# Keeping mum in clinical supervision: private thoughts and public judgments.

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## ABSTRACT

The seemingly obvious claim that people prefer to keep mum about undesirable messages – termed 'the MUM effect' – was initially reported in the psychology literature in the 1970s. More recently, it has been discussed in contexts including performance appraisals and the reporting of unsuccessful projects in workplace settings, but only sparsely in educational ones. We performed a narrative literature review on the MUM effect in order to understand the implications for clinical assessment. We suggest, that as a pervasive phenomenon, the MUM effect can both help to explain the difficulties that some assessors face when delivering undesirable messages (including feedback or ratings) and offer new insights in how to deal with such issues. This paper summarises the extensive literature on the MUM effect, including its manifestations and modifiers and discusses how the effect may be used to consider issues faced by many clinical supervisors faced with delivering 'negative' assessment messages to trainees.

**KEY WORDS**

Clinical education, Evaluation/assessment of clinical performance, Postgraduate training, Testing/assessment

## Introduction

Imagine this scenario. It is the end of a busy clinic or long ward round, and you are scheduled to observe a trainee in a workplace assessment. As you do so, you see that the trainee is struggling with the task and you have 'negative feedback' to give. What goes through your mind? And then, what do you say?

Many clinical supervisors are reluctant to speak their mind when they have formed an unfavourable view of a learner's performance (1,2) . This can lead to "vanishing feedback" (3), where a learner is not given sufficient information about their performance, in particular that their work is unsatisfactory. At an extreme, this results in the 'failure to fail" those learners who do not meet standards (1,2,4). The reluctance to communicate unfavourable assessment news, whether summative or formative in nature, can be directly linked to a psychological phenomenon known as 'the MUM effect'. Since the 1970s, a range of psychological and management studies have confirmed that, in general, people are likely to keep Mum about Unpleasant Messages (MUM) (5). This focussed body of empirical research remains relatively unexplored in the medical education literature, although constructionist notions of politeness have been used to explain a lack of direct expression in some circumstances (6). The MUM effect literature has much to offer medical education, particularly when "failure to fail" persists in clinical supervision, despite our best efforts (4). This paper narratively reviews the extensive literature on the MUM effect, exploring its manifestations and causes, then offers implications for clinical assessment and feedback processes.

In 1970, in the department of psychology at the University of Georgia, Rosen and Tesser sought to test the "common sense notion that people will be more reluctant to communicate information which is negative rather than positive for the recipient" (5). This seminal MUM effect experiment examined the relationship between the nature of the message and how people deliver it (5). Subjects, who were unaware that they were being studied about MUM, when given an opportunity to deliver an urgent message did not deliver it as completely when the news was bad compared with good (5). The authors subsequently rephrased the aphorism "no news is good news" to: "no news is bad news" (7). The MUM effect as a phenomenon has since been studied extensively, both in experimental (8–10) and in natural environments (11–15). The latter has included the role of MUM in performance management of workers and in industries ranging from information technology (12–14) to high school education (11).

MUM appears rarely in the medical education literature, except fleetingly as a possible explanation for rater bias (16). However, rater cognition literature is predominantly

focused on understanding how assessors' ratings appropriately reflects learner performance (17). While concern about "unpleasant repercussions" (18) is noted as influencing ratings, it is considered as a 'contextual' factor (17) or a source of rating 'variability' (18). The MUM literature has a different focus. It suggests that, even if the appropriate assessment judgements are made, the assessor may not *communicate* these judgements – either as ratings, written comments or verbal feedback information – to the learner.

Clinical supervisors' inability to turn private thoughts into public judgements has serious implications for clinical assessment and healthcare more broadly. Firstly, it is a source of error in rating learners, as is described in the rater cognition literature (18). This may be somewhat ameliorated by the use of multiple raters and to this end, recent 'programmatic' approaches to medical education assessment rely on frequent formative 'low stakes' assessments from multiple raters (19–21). Secondly, the medical education feedback literature suggests assessors withhold information about performance ("leniency bias"), which prevents trainees from learning appropriately (22). Over thirty years ago, Ende noted the same issue, which he called "vanishing feedback": "… the well-intentioned teacher talks around the problem or uses such indirect statements as to obfuscate the message entirely. The student, fearing a negative evaluation, supports and reinforces the teacher's avoidance. The result is that despite the best of intentions, nothing of any real value gets transmitted or received." (3) Finally, at the most extreme, clinical supervisors let learners pass when they have not yet met the required standard (4). "Failure to fail" denies remediation or extra support to poorly performing trainees and results in a missed opportunity to intervene and improve performance before a serious consequence occurs, such as harm to patients. Critically, interventions aimed at addressing failure to fail, including faculty development, have resulted in only limited improvements (4). In other words, this is a persistent problem with wide-ranging consequences for healthcare education and practice.

As we outline below, the MUM literature suggests that keeping mum is pervasive (23–26). More usefully, the MUM effect research also notes that individuals keep MUM in different ways (27–29) and "vary in the extent they engage in these behaviors" (30) . Through exploring these behavioural manifestations of the MUM effect, we may find some solutions to the perennial challenges of asking clinical supervisors to communicate their judgements, provide valuable feedback for improvement and prevent those who have not met the standard from progressing.

After reading of the MUM effect in Williams, Klamen and McGaghie (16) we performed a narrative literature review (31,32) to explore the phenomenon further. We chose a narrative review as we wished to broadly review what has been reported about the MUM effect in the published literature, without being limited to a narrow research question. To

address the key concern about narrative review's limited reproducibility (32), we provide our search strategy. We searched Ovid Medline and Discovery for the phrase "MUM effect" and the yield was read for any relevant articles, defined as all papers which reported on the MUM effect. The majority of these were original studies, in a variety of settings. Two were discussion papers / propositions / models (33,34) and one was a summary chapter written by the original investigating authors (35). The latter included conference proceedings not available elsewhere. All reference lists of these articles were also reviewed, and any which also reported the MUM effect were obtained and included in the review. The search was repeated several times during the writing of this paper up to April 2017 and new articles incorporated as found (up to November 2017).

The findings from the articles were clustered together into three themes – those which describe what MUM behaviours look like, those which explore potential reasons for the MUM effect and those which consider factors that can influence MUM behaviours. These were derived from a mixture of inductive and deductive methods. The categorisations for the behaviours and reasons were taken from pre-existing frameworks reported in the MUM literature (5,23,27,35,36). All articles were thematically analysed against these. The influencing factors were derived inductively across papers. All papers were read and all influencing factors were recorded. These were then clustered together using principles of thematic analysis (37). These themes are presented in the next sections and following these, we propose how this literature might usefully inform clinical assessment practices.

## Behavioural manifestations of the MUM effect

The MUM effect is frequently observed through the following behaviours: delaying giving the message; distorting or 'sugarcoating' the message; and avoiding giving the message.

### Delaying behaviours

The earliest research notes the MUM effect manifests as a 'delay' in delivering bad news (5,27,38). For example, Tesser, Rosen and Tesser showed in a field study that bad news delivery (rejection of a disability financial aid application) was delayed compared with good (27). Similarly, Benedict and Levine showed in an experiment about performance appraisal that simulated supervisors delayed giving performance ratings to lower performers (29). Delay in delivering bad news has not been demonstrated in all studies however (28) and it is noted that delay may even be beneficial to communication in some situations, serving a

"social function" (26) of announcing the valence of the message to come and so helping tellers in their task (9,26).

### Distorting behaviours

Distorting unpleasant message has also been observed in laboratory settings (28,29,36) and distortion of the message has been reported in business settings as "sugarcoating" (34,39). For example, Ploeger and colleagues described the use of indirect phrasing to deliver a negative message in a business setting, such as declining an unethical request in a written simulation experiment with working adults (40). Modelling the effects of 'sugarcoating' in organisational learning suggests some small amount of distortion of the message may in fact promote communication but when present beyond a certain point, effective communication deteriorates (34). This aligns with the linguistic analysis that Ginsburg and colleagues have conducted on written comments in clinical work-based assessments, which shows extensive 'hedging' for both good and bad performers (6).

### Avoidant behaviours

Significantly, communicators of bad news may avoid delivering some or all of a negative message, (5,11,33,39). For example, over half of the principals interviewed in a 2006 naturalistic study admitted to initially ignoring or avoiding the problem of underperforming teachers, including an extreme example of a principal begging students to behave to avoid managing their teacher's failings (11). Correlational studies employing a MUM scale suggest that avoidance of delivering negative messages may be modified by the communicator's personality and the norms of the organisation involved (39).

## Why does the MUM effect occur?

Explanations for why individuals stay MUM include: the "communicator's self-concern", the "communicator's concern with the recipient" and the "communicator's concern with norms" (35). These are useful categories, although under-theorised (26). It is worth noting that there are other also factors in play; the communicator's personality or the climate of an organisation may have a significant impact on delivery of negative messages (39,41,42).

### Self-concern

MUM behaviours may result from a communicator's desire to avoid bad feelings in themselves, though Rosen and Tesser highlight that "being put into a situation that makes transmission of unpleasant messages possible creates a tension system within the individual regardless of whether or not he actually transmits the message" (5). Early experimental studies (5,43) showed that communicators may experience feelings of guilt when sharing bad news and that MUM behaviours are motivated by a desire to avoid this. Communicators may

explicitly consider how their delivery of news will be viewed by receivers (24) and the deliberate use of delay may intend to minimise a negative evaluation of the communicator (23). A further reason given for MUM behaviours is to avoid the negative change in the communicator's mood that occurs (or in fact is required) when delivering bad news (35). This resonates with the clinical assessment literature: many studies report the emotional toll on clinical assessors when failing a trainee (4).

## Concern for others

The communicator's concern for the recipient of an undesirable message can also lead to MUM behaviours. The common assumption is that people will want to receive good news and conversely, not want to receive bad and this may influence the communicator's behaviour (35). In an experiment where participants had the option to give feedback on interpersonal skills, Conlee and Tesser tested the effect of clearly stating a recipient's desire to be told news, even if bad. They found that while knowledge of the recipient's desire to hear news did increase its transmission, it did not entirely eliminate the MUM effect (44).

A communicators' belief of how a recipient may respond to a negative message can influence their decision to tell or not. "Communicators prefer not to put the recipient in a negative affective state" (35) and appear sensitive to the "emotional impact a particular message would have on the relevant recipient" (35). These seem like very natural empathetic responses, as most do not wish to cause distress. Reluctance to deliver a negative message may be due to the communicator's wish to avoid causing unhappiness in another, their fear of being with a person who is upset by bad news, whom they may be unable to calm down, or their fear that an emotional recipient will judge them harshly (35). Tesser and Conlee showed that bad news was told more readily to a calm than to an emotional recipient (Tesser and Conlee 1973 reported in (35)). Likewise, clinical assessors report an eagerness to avoid upsetting learners (45) or consideration of the broader impacts of failure upon their career (4).

## The communicator's concern with norms

Communicators' desires to conform to societal rules or norms represent a third possible explanation for MUM behaviours (35). This aligns with notions of 'politeness theory' explored in clinical assessment (6), where giving good news is seen as 'face-saving' and therefore normative. Again, this is reported to occur in the clinical assessment setting: "there is sometimes a culture within medicine where the critical discussions with [trainees] are often avoided" (46).

## What can influence MUM behaviours?

Many factors may modify the expression of MUM behaviours and it is these that take the conversation beyond what has already been explored in the clinical assessment literature. While there is some research around personality characteristics (39,47), age (40) and gender (5,29,40), we focus here on factors that are modifiable and therefore most relevant to medical education.

### Responsibility to communicate

Clearly assigning responsibility to communicate a negative message to a communicator has been shown to affect behaviour. Tesser, Rosen and Batchelor (48) found that in an experiment where participants were given the responsibility to communicate a piece of news felt more obliged to do so, compared to those who were asked not to or where they were allowed to decide; more recent work also supports this (42).

### Consequence of the message

Perception of consequences may affect MUM behaviours. In a performance management setting, Smith and colleagues surveyed government employees with supervisory experience and reported that, as the importance of a performance appraisal increased, so too did communicators' levels of discomfort (49). Similarly, Cox and colleague have shown some relationships between discomfort and MUM behaviours (50). Uncertainty about the consequence may also affect the delivery of the message. Weenig's experimental work suggests that bad news with indefinite consequences is delivered more readily than bad news with definite consequences, due the former being regarded as "more urgent and more helpful" (51).

### Anonymity

The MUM effect may still occur in anonymous situations (52), however studies are mixed as to the influence of anonymity on MUM behaviours (23,53). Early experimental studies clearly describe reluctance to communicate an unpleasant message on behalf of someone else (5). This also has possibly important implications for 'programmatic assessment' systems where the message and the decision-makers can be separated (54).

### Job satisfaction

A communicator's level of satisfaction with their work situation may influence their willingness to deliver undesirable messages. In the management literature, Cox and colleague suggest levels of job satisfaction and trust in a supervisor are negatively related to self-

reported MUM behaviours (15); Bisel notes that factors such as job security may affect willingness to deliver bad news (33).

### Pre-existing relationship

In general, MUM behaviours may be modified by the presence of a pre-existing relationship between the communicator and the recipient. As noted above, trust in a supervisor may decrease the likelihood of MUM behaviours. Weenig and colleagues suggest that the closer a relationship between the two, the more likely that information exchange will occur (51,55) though results of other studies are less conclusive (8). Smith, Harrington and Houghton found that the duration of a relationship did not influence the level of performance appraisal discomfort reported by the assessor (49). Hierarchical differences are also relevant. For example, Ploeger, Kelly and Bisel showed that subordinates were more likely to keep MUM to an employee senior to them (40). These relationship findings are highly relevant to medical education, particularly with the current emphasis on feedback as a relational act (22,56,57).

### Medium

The medium of the message may be significant, but this is a still a matter for debate. In an experimental study, Sussman and Sproull found less distortion of 'negative' feedback regarding the presentation of a student resume with computer-mediated methods, in comparison to telephone or face-to-face (58). Similarly, a meta-analysis showed that respondents were more likely to give extremely positive responses to questions in telephone interviews, compared with other less direct methods (59). In contrast, Dibble found that mode of delivery did not affect the self-reported level of reluctance to communicate (email in comparison with face-to-face) (26), though this was a theoretical situation with news to be communicated between friends.

### Cultural differences

The MUM effect has been described as a 'universal' tendency affecting all people, (60) and reports of MUM behaviours have come from many settings (for example in studies from Asia (12,14), Israel (11), the Netherlands (51,55) and one across Paris, Madrid, London, Geneva and Frankfurt (52) and in anecdotal descriptions from the UK (61)).

## Practical implications for medical education.

This literature review suggests that the MUM effect is pervasive, can lead to a complete avoidance of delivering or distortion of an undesirable message, and persists across cultures and workplaces. The research suggests a fundamental reluctance of people to communicate negative messages. This has significant implications for clinical assessment.

The MUM effect offers a new way of understanding the problems of clinical supervisors' capacities to provide an 'accurate' rating, deliver 'honest' feedback, or 'let through' a medical student or trainee who has not met requirements. It suggests that, from a rater cognition perspective, any attempts to encourage judgements that reflect performances – such as training, form development and scale modifications – need to also take account of how the message will be delivered. It also explains why phenomena such as "vanishing feedback" and "failure to fail" are still so pervasive in medical education, often despite our best efforts (4).

There are five immediate, practical implications of this work for clinical performance assessment settings.

1. **The MUM effect will inevitably occur.** If the MUM effect is pervasive, then this supports the value of the programmatic assessment movement (19–21). It appears that people vary in their extent of MUM behaviours and therefore, having many points of assessment from many different assessors, each with low stakes, should reduce the impact of the MUM effect, although not eliminate its occurrence.

2. **Focussing on the benefit of the message for the learner** may reduce the discomforts for assessors and associated MUM behaviours. Education is not the same as performance appraisal. In education, poor performance messages can be thought of as good opportunities to learn, or even 'good news'. This aligns with the notion of the educational alliance, where the trainee will trust a supervisor who they believe has their best interests at heart (56). This may be the key for understanding how a pre-existing relationship can affect MUM behaviours; working towards someone's best interests is clearly not the same as protecting them from any discomforts.

3. **MUM manifestations reduce when delivery of undesirable message is seen as a part of the job.** In the same way that the same clinicians don't avoid delivering bad news to patients, we can encourage and support clinical supervisors to see themselves as educators, and with this comes the need to provide undesirable messages as part of feedback processes. This is important as some supervisors report reluctance to provide negative feedback (62) and some report a role conflict between teaching and assessing (63).

4. **Not all MUM behaviours may be harmful – the extent is relevant.** As highlighted, there may be benefits to some delay in delivering messages (9,26). It may also be that some 'sugarcoating' (34), may make the message more 'palatable' although there is reason to doubt the efficacy of sugarcoating coating (64), and sincerity is very important (65). It may be that sweetening can be seen as motivational encouragement rather than part of the performance information; this is an area for further investigation, not just within the MUM literature.

5. **We should be more forgiving of our assessors.** This body of work suggests that MUM is a natural human tendency and therefore all the faculty development in the world may not resolve the reticence to deliver undesirable messages. Providing clinical supervisors with information about the MUM effect will not necessarily 'fix' the problem, but it may permit assessors to understand why, when and how they withhold information from trainees and therefore take steps towards regulating their behaviour or allow them to excuse themselves from feedback or assessment duties if they find the effect to be overpowering. It is important that assessors realise, that regardless of the system, they can take responsibility for ensuring that trainees who do not meet performance standards are not allowed to progress.

While the MUM effect may be pervasive, it is not universal, and different assessment contexts may constrain or enable certain behaviours. One profound difference is whether the assessment's purpose is primarily as feedback (formative) or if it is primarily for recording a judgement of progress (summative). Providing feedback after a formative work-based assessment is not the same as communicating the results of high-stakes examination. There may be different ways to manage MUM within different types of assessment purposes.

Clinical supervisors are acutely aware that feedback is a core part of their remit; across the health professions clinical supervisors identify feedback as one of the most urgent areas for faculty development (66). Bing-You and colleagues suggest (22) that a few, suitable, supervisors should specialise in the feedback role and we should target our efforts into building these clinicians' sense of identity as educators. This may be one way to reduce the MUM effect; in these situations, the expert feedback provider would see articulating unfavourable performance information as a key part of their role, one which was not necessarily a 'bad message' for the trainee, and could draw from 'delaying' and other tactics to make the message more effective, as needed. Additionally, in line with feedback being more than just the message (67) this places performance information provision as just one part of a larger series of feedback exchanges or relationships; to use Bing You's analogy, just one step in the dance (22).

Sometimes, assessment messages are not developmental. In these instances, when the primary purpose of assessment is making high stake progress decisions, then there may be other approaches to "control" the MUM effect. Once again, ensuring that clinical supervisors see that delivery of the message is part of their core job is very important. Beyond this, it may be that multiple message givers may ameliorate the MUM effect. This is possible in two ways. Firstly, multiple messages may be collated, as in programmatic assessment. However, as one of the key insights from the MUM literature is that 'bad news' will be under represented, it may be worth considering that singular poor assessment results should result in other assessments being given stronger scrutiny. Of course, this does not suggest that a

singular poor assessment results is more or less accurate but as, across the population, assessors are more likely to withhold undesirable messages than deliver them, then a negative assessment should not be overlooked. Secondly, delivery of the message itself can be through a panel or a group, so that the natural MUM tendencies can be attended to through consensus rather than relying on an individual to be the bearer of bad news.

The ideas that we present here are speculative: there is considerable opportunity for further research into the MUM effect within medical education. At the preliminary level, this is work to establish how MUM behaviours manifest within clinical assessment. At the next stage, some of the suggestions that we have explored above, could be investigated. Additionally, the role of the less harmful MUM behaviours – small amounts of delay in delivery until the time is right or 'sugarcoating' to ensure digestion – is a key area for future consideration.

To return to our initial scenario of an assessor poised to give feedback to the trainee struggling in a workplace assessment, we hope this discussion provides some insights, potential solutions and further areas for consideration. Awareness of the MUM effect, especially in relation to the consequence of an assessment (formative or summative) we believe is an important first step. Using the power of the group to communicate unfavourable ratings may be a productive approach. Finally, reframing delivery from one of a 'negative' assessment message to one of helpful developmental information, especially when communicated by a specialist educator who has commitment to assessment may be an important step towards helping these issues.

## Limitations of this review

This review employed a narrative literature technique and presents a review based on themes discussed. While a thorough search of the published literature was undertaken, it is important to acknowledge that it is not a systematic review. Though searches were repeated several times during the writing of this article, it is possible that some articles have been missed (32). Further, no assessment of the quality of articles has been made for this review and all articles on the topic of the MUM effect have been included without preference to their quality. As such, the conclusions of this review are subject to bias through the potential omission of works and lack of quality assessment (31). As discussed, the articles presented discuss the MUM effect from perspectives outside of medical education settings, but the universality of the effect highlight their relevance to us.

## CONCLUSIONS

Difficulties with the delivery of undesirable assessment information is well recognised in medical education in the rater cognition, feedback and "failure to fail" literature and they extend beyond considerations of form development, scale modification and assessor training. The communication of the message is just as important as the development of the rating and comments themselves, but this aspect has been largely overlooked to date. The MUM effect offers both a new understanding of why the delivery of poor performance messages is difficult for some and new insights on how we can help clinician assessors deliver their intended assessment messages to trainees. These include focusing on their role as an educator and the benefits of delivering of an accurate message, even if it is negative, to the trainee's overall development. After all, trainee development and ultimately improved patient care are the prime goals of assessment.

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