Evaluating Without Fear

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Part of the responsibility of every teacher is evaluating student performance. In medical education, evaluation is particularly important because we must eventually certify that our graduates are competent to provide health care to the general population. Yet, evaluation is perhaps the least favorite task of many teachers.

Family physicians, in particular, seem to be uncomfortable with evaluation. We are much more willing to have students in our offices, share experiences, teach techniques, and provide guidance than we are to fill out a form indicating how well a learner performed. Why is this? What are the barriers that keep us from this important task? There are many factors, including time pressures, past experiences, and general aversion to paperwork. Perhaps the greatest barrier, though, is feelings. Family physicians are trained to be compassionate and empathetic. We know it doesn’t feel good to receive anything less than a perfect evaluation, and the possibility of creating discomfort in one of our learners makes us uncomfortable. Hence, we try to avoid it, either by being overly generous or by evading the process altogether. However, if we are to fulfill our obligations as teachers—to the
learners, the programs, and society—we have to give complete and honest evaluations. Fortunately, evaluating student performance doesn’t have to be an unpleasant or threatening experience. With the right mind set and proper clarification in advance, evaluation can be quite simple, straightforward, and rewarding.

**The Difference Between Feedback and Evaluation**
Feedback and evaluation are often confused. Both are essential to the teaching process but are quite different. Feedback is frequent, ongoing review of strengths and areas for growth, with suggestions for further study or practice. The intent of feedback is to improve performance.

Evaluation has many types and purposes, some of which are similar to feedback. For the purpose of this article, we will limit our use of the term evaluation to the most common type asked of clinical teachers—the final evaluation of performance at the end of a course or rotation. This summative evaluation may be defined as a comparison of actual performance to requirements or standards. The intent of this summative evaluation is to document achievement or competence.

**The Process of Evaluation**
In its simplest form, evaluation includes 4 steps:

1. **Define Expectations**
   At this specific point in the student’s or resident’s training, what should the learner be able to do? This is the most difficult step—and the most critical. Definition of these expectations is the responsibility of those designing the program, so this task should generally not fall to the community preceptor. Don’t hesitate to ask the course or program directors to provide you with clear, specific expectations for what students or residents should be able to do, both at the beginning and at the end of the experience in your office. The directors have to do their part before you can do yours. You can help by making sure these expectations are clear to learners when they start working with you.

2. **Define Performance**
   How does the student or resident perform? What can the learner do? To answer this, you need information, which can come from direct observation, observations of others in your office (physicians, nurses, and other staff), and/or comments from patients. You may also wish to incorporate some self-assessment by the learner of his/her own performance.

3. **Identify Differences**
   Simply compare the performance with the expectations. Which ones were met? Exceeded? Are there some that were not yet achieved?

4. **Document**
   Write it down. Soon. The longer you wait for the paperwork, the harder it will be.

**Forms and Formats**
Clinical teachers are often provided with a form on which to give their summative evaluation. These forms vary widely in structure and degree of specificity. In general, the more behavior specific the form is, the more clear-cut the evaluation
process can be. Community-based faculty should not hesitate to let the program directors know whether existing forms are helpful or a hindrance and what changes might make it easier to give objective, specific assessments. In North Carolina, feedback from preceptors led to the design of a uniform evaluation instrument used for all family medicine clerkships in community practices in the state. Designed with input from community-based teachers, this form has received positive responses from preceptors and has led to better evaluation data on the students.

**Conclusions**
Evaluation doesn’t have to be threatening. By focusing on clear expectations and specific aspects of performance, evaluation can be made much more helpful to learner and teacher alike.

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