Feedback and evaluation are separate entities. Feedback is informal, nonjudgmental and brief, and hopefully provides information about recent performance to promote positive change. Evaluation is, by its nature, judgmental. It measures learners against their peers, occurs at specific times (e.g., at the rotation’s end) and will determine whether learners pass or fail a rotation.

As a rural preceptor, you may be the only instructor who sees a learner perform in multiple settings as he or she encounters multiple undifferentiated patient presentations and works with many health care professionals. As such, your feedback and evaluation will provide an important, holistic view of the learner, and you will be able to more accurately judge the student’s strengths and weaknesses.

For feedback to be fair and effective, the preceptor should know what expectations are appropriate for the learner’s level of training. For the occasional teacher, this may be difficult. To become familiar with the school’s expectations of the rotation, it can be helpful to review the objectives for the rotation. As you become more experienced, delineating appropriate expectations becomes easier. To discuss your expectations with the learner early in the rotation. Make the learner aware that feedback is a normal component of your daily interactions. Identify feedback, because it is often not recognized as such by the learner.

To be effective, feedback should be specific to what was observed, occur soon after the event and be limited to 1 or 2 items. Although there are those who feel that the preceptor should not use second-hand information (e.g., from other health professionals or patients), we feel it should be shared, provided the information is specific and helpful. For example, if a nurse tells you that a learner was rude, ask what exactly the learner did. Often the learner is oblivious to the affront, and it was unintentional. If a patient complains, you will need to discuss with the patient what the issues were. Vague comments are not useful; however, if you get numerous complaints that the learner “didn’t listen” or “seemed to be in a hurry” they will need to be passed on to the learner. Often, vague comments will necessitate increased direct observation of the learner, if possible, to understand what behaviours are giving rise to the problem.

Negative feedback will demand concrete examples; it is not enough to tell the learner they seem distracted or unfocused — they will want to know on what you based your observation. Recipients of negative feedback will often become defensive; this is a natural response, and the preceptor should try not to respond emotionally.

It has been suggested that feedback can be given in a feedback sandwich. The critical feedback is “sandwiched” within positive feedback. The intent is to lessen the sting of the negative and avoid a feeling of injustice. We don’t find this particularly useful, because the positive comments often seem contrived when sandwiched. We do, however, consciously try to provide positive feedback at regular intervals so that the learner is aware that there is a culture of feedback. It is sometimes helpful to phrase the feedback in the vein of “you
are doing ‘that’ well but you would be an even better clinician if you did it ‘this’ way.” In addition, it is helpful if the feedback is given in context of the learner’s level, as in, “Most third-year clerks struggle with this…” If you feel the learner is seriously behind the expected level, it is essential to call the postgraduate or undergraduate director of the university and discuss it.

Although feedback should be informal and supportive, evaluation is formal and judgmental. It is important that you as the preceptor be aware of what is being evaluated; a quick perusal of the rotation evaluation form before the learner starts will provide cues to the behaviours and skills expected. If you have serious concerns, these must be addressed with the learner early in the rotation and a program of remediation initiated. If this is not done, the student cannot be failed. Again, if you have serious concerns about the learner’s performance, call the appropriate directors and they will be able to direct you through this difficult process. Fortunately, most medical students and residents are good to excellent, and this should be a rare occurrence in your practice.

Medical residents and students are high achievers who have performed very well all their lives. Many struggle with being anything but “excellent.” Although it may be tough for students to swallow, the reality is that in medical school the vast majority of them have found their intellectual and academic peer group. Many find this difficult to adjust to and threatening to their self-esteem. There are preceptors who avoid their discomfort in judging others by rating everybody as “excellent.” This creates difficulty, particularly if a learner has problems in other rotations, because this “excellent” evaluation creates an unrealistic self evaluation and will be used to defend the learner’s performance. It is essential to be as fair as possible in your evaluations. Learners do appreciate realistic evaluations when they are put in context with other students and residents and performed face-to-face.

In addition, it is important to place as high a value on the portion of the evaluation that assesses communication and professionalism skills as the portion evaluating clinical skills. Residents and students need to be told whether they have good interpersonal skills and why this is essential to being a good physician. Many students and residents value knowledge and clinical skills over their ability to communicate and perform well within teams.

Giving feedback and evaluating learners is an important part of the preceptor’s job. Appropriate feedback is important for both strong and weak students and, when given in a nonjudgmental, supportive manner, is much appreciated.

Competing interests: None declared.

REFERENCES