can only be inferred. It is hoped that, in time, a cognitive written examination can be devised that reliably samples the domain of medical knowledge learned in family medicine residency programs, and that valid criteria can be developed to show growth over time. In the meantime, it would be helpful if every test were to give immediate feedback and references to further information sources, thus providing a learning experience as well as a more relevant self-assessment for the residents.

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Evaluation of Clinical Skills: An Asset-Oriented Approach

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Evaluation techniques may influence or model a physician's approach to patients. Since medical schools and postgraduate training programs often model punitive or deficit oriented evaluations, it is not surprising when medical students and residents use the same approach with patients. They often ask only "What is wrong?" (What is the pathological condition? What is the deviation from the norm?) This disease oriented approach is not a primary care model, which is prevention oriented, and therefore, needs to identify skills necessary to maintain health.

During the past two years the University of Wisconsin Department of Family Medicine and Practice has experimented with an asset oriented approach to clinical skill evaluation. It focuses the evaluations primarily on positive characteristics including talents, accomplishments, skills, and abilities.

Specifying and praising the student's skills does not rule out demonstrating and correcting inadequacies. Appropriate skills, however, should not be taken for granted because they are "expected." Unless "expected" behaviors are clearly specified and periodically reinforced, they may begin to decrease in frequency.

An asset oriented approach also redirects the resident's attention to patients' behaviors. For example, some patients are called "turkeys" or "crocks": pejorative labels identifying deficit characteristics (traits we do not like and want to reduce). Unfortunately, that labeling may act as a perceptual set for the next visit, and this negative bias is difficult to change once established. By concentrating on deficits, we lose sight of skills or talents. Attending to deficit behaviors (eg, whining, demanding, non-complying, complaining) is frustrating for the physician and dysfunctional for

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the patient. If, however, the physician identified and commended skill behaviors (eg, smiling, negotiating, good history reporting, problem solving, communication skills), the physician might feel better about spending time with the patient and optimistic about possible behavior changes. The patient also might have more functional options to use to get the physician's attention.

Methods

In September 1977, the Department of Family Medicine and Practice at the University of Wisconsin began to conduct asset oriented evaluations of residents. A three-member team of the Madison Residency Faculty (each representing a different discipline and/or experience background) observed actual resident-patient encounters in order to evaluate the clinical performance of the residents. This team observed the resident and recorded his/her skill strengths and deficits using a series of performance objectives and interviewing skill criteria which have been developed in the Madison residency. Following the patient encounter, the team met with the resident to give feedback in an asset oriented approach using the performance criteria as well as a written patient feedback form for that encounter.[1] Following this supervisory feedback, the resident was asked to evaluate the efficacy and style of the evaluation team in giving feedback, ie, "Were the criticisms justified?" "Did we (evaluators) present our criticisms, both positive and negative, in a way that facilitated learning, or did you feel under attack and threatened?"

Results

Prior to introducing an asset oriented evaluation, family practice residents rarely requested evaluations. From July 1977 until June 1978 only 1 out of 38 residents specifically requested a traditional evaluation from the clinic directors. However, 15 of 16 residents who participated in an asset oriented model from October 1977 until January 1978 requested further evaluation of this kind. A supervisory feedback scale allowed the residents to comment on and rate the behavior of the evaluators. The following types of items were rated on a 1 to 5 scale in which 1 represented "poor" and 5, "outstanding": identifying specific positive behaviors and those which needed improvement; giving reasons for labeling behavior as positive or deficient; giving feedback in a manner which minimized anxiety; accepting feedback positively. Evaluations received an average of 4.5 across all items. More importantly, no item was rated less than 4.0.

The residents were asked to write comments on the following questions: What behaviors did the supervisor perform well? What specific behaviors should the supervisor improve? The improvement most frequently requested by the residents was to "do more of these evaluations."

Discussion

A frequent objection to clinical evaluation in medicine is the emphasis on deficiencies with little attention to positive aspects of a student's clinical performance.[2] This negative emphasis probably contributes to the student's discomfort with evaluations in general.[3] Clinical evaluations can provide excellent opportunities for learning and refining interpersonal skills.

Learning theory demonstrates that students learn more efficiently, are more creative and motivated, are less anxious, and feel more confident when they are exposed to teaching environments which reinforce desirable behavior rather than punish undesirable behavior.[4] Punishment rather than reinforcement, however, is the standard in clinical medical education.[5] Punishment is an inefficient educational technique for several reasons: (1) while it suppresses behavior it does not necessarily teach a more appropriate skill; (2) unless it is consistently applied the undesirable behavior may recur; and (3) it may create an avoidance response to the learning environment itself. Any one of these outcomes are undesirable goals in medical training. Educational techniques based on positive reinforcement, however, produce the opposite results.[6]

An asset oriented evaluation specifies desirable behaviors, increasing the probability that those behaviors will be repeated during future patient encounters. Specific reasons are also given to justify the positive feedback. For example, "I liked the way you stated an agenda at the beginning of the encounter because it gave the patient a clear idea of what you thought was important to accomplish in that visit."

Emphasizing and evaluating assets prior to weaknesses also helps the resident to accept an evaluation of deficits more confidently and less defensively. Residents observed in the University of Wisconsin Department of Family Medicine and Practice-Madison Residency Program consistently reported that this system of feedback reduced their anxiety. Additionally, they appreciated the specificity of the supervisory feedback.

In any evaluation, attention to deficits is important, but in an asset oriented system these are pointed out *after* competencies are reviewed. In this way, the resident's skills can be applied to the problem areas. For example, a resident may have a problem knowing what to ask next in an interview, but have the ability to organize the patient's medical problems by summarizing blocks of information. This resident could use his/her organizational skills to help summarize the interview at points of uncertainty, allowing time to think, and also giving the patient an opportunity to change or add to the information summarized.

There is no reason to believe that physicians who learn under a punitive model are more competent than physicians who learn under an asset oriented model. The educational and humanistic advantages of the latter indicate a need to test that empirically. An asset oriented model provides more than evaluation alone. It offers the physician an additional learning opportunity, encourages the physician to be creative, models alternative physician-patient interactions, and motivates the physician to request further evaluation.

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