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DIFFERENT POINTS OF VIEW IN THE EVALUATION OF THE RESIDENT PHYSICIAN IN MEDICAL CLINIC PROGRAMS[1]

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ABSTRACT

Introduction: This study focuses on the evaluation of the resident physician on professional training process. **Objective:** To understand the evaluation process of the physician residing in medical clinic programs, under the eyes of different actors. **Methods:** Qualitative, descriptive research developed in two residency programs in medical clinic, with coordinators of the two programs, eight preceptors, and 15 resident physicians, totaling 21 participants. Data collection with focus group and recorded interviews, analyzed through content analysis, in two thematic categories were performed. This article presents the theme "the evaluation of the physician resident from the points of view of the different actors involved in the evaluation process". **Results:** There was a disparity in the perception of the evaluation among the different actors, subjectivity in the evaluation, inexistence of clear rules and knowledge of all, indicating fragility in the evaluation process. **Final Considerations:** It is recommended to adopt structured assessment strategies in medical residency training and to allow those involved to know the evaluation process.

Keywords: Educational Measurement. Employee Performance Appraisal. ProfessionalTraining. Internship and residency.

INTRODUCTION

The fragility of medical education in Brazil has been studied, evidencing over the years the increase of courses, without the necessary quality follow-up of number of vacancies. The deficiency of training, in part, have been met with medical residences. In this sense, identifying how professionals are evaluated, whether only technically or from the point of view of integral care and ethical principles, can contribute to their formative process[1-2].

It is assumed that the means of evaluation in medical practice residency programs are not clearly established in relation to the theoretical possibilities (diagnostic, formative, procedural and summative evaluation)[3-4] and the return to resident physicians, as well as the use of formally established instruments to evaluate the progression of professionals throughout the process.

Articles 13 and 14 of Resolution No. 02/2006, the National Medical Residency Commission (CNRM) recommends the periodic evaluation of the resident, at least every trimester, either by practice, unwritten or written test, or attitudes scale, as well as the completion of a monograph to complete the course[5]. Added to this, the changes in the manner of medical residency, described in Law No. 12,871/2013-MS/MEC[6], with a date scheduled for adaptation of the courses until 2018. Thus, to highlight the way in which the programs evaluation is important to contribute to vocational training.

The teaching-learning process during medical residency is still poorly studied. Most of the existing work deals almost exclusively with the qualification of the teaching staff, the working conditions of the residents and the organization of the programs[7]. As training occurs, what and how residents learn, such as the evaluation process, is still little discussed, which motivated the study. Thus, this research sought to answer if the evaluation of the medical professionals in the residence programs is done, at what time during the training, and how it occurs. Thus, the objective was to understand the evaluation process of the physician residing in medical

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clinic programs under the eyes of the different actors.

METHODOLOGY

Study with qualitative, exploratory and descriptive approach, allowing proximity to the problem and the description of the characteristics of the researched population, in this case, coordinators, residents and preceptors regarding the methods of evaluation used in the process of professional training of the resident physician.

The research was developed in western Paraná, in two health institutions, which are part of the hospital care network of the area, a public teaching hospital, named institution A from now on, and a private teaching hospital, named institution B. Programs are linked to the medical school of both institutions.

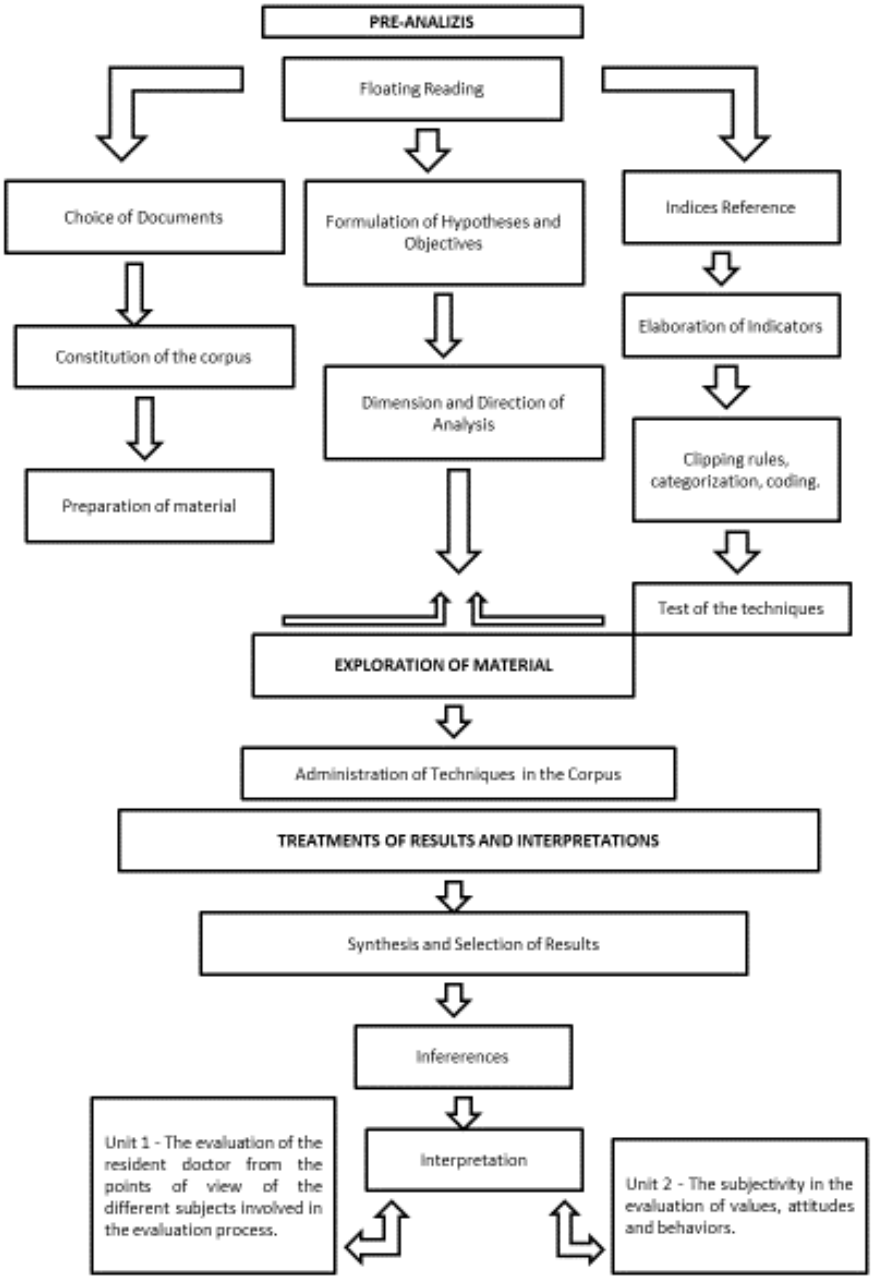

Figure 1.Analysis Development Scheme.
Source: The authors

The medical practice residency program of institution A lasts two years, with a minimum annual workload of 2,880 hours of activities and a total of 5,760 hours. It offers six vacancies per year, was approved by the CNRM in 2003, began its first class in the year 2004, having trained 37 medical clinic specialists. The medical residency program of institution B is characterized by having a duration of two years, a total workload of 5,760 hours, offering two vacancies per year, having been approved by the CNRM in 2012, and graduated up to the time of data collection, two medical clinic specialists.

The research participants were all the professionals who worked in the medical clinic programs, and accepted or had time available to participate, being the two coordinators, five preceptors in A and three preceptors in B and resident physicians, eight of them in institution A and three in B, totaling 21 participants. Both coordinators and preceptors have been active in programs since its approval.

For data collection with the coordinators, a semi-structured interview was conducted, with an adapted script[7-8]. For data collection with preceptors and post-graduate students, four focal groups were done (two residents and two preceptors, one in each course), with an average duration of one hour. Both the activities with the focus groups and the interviews with the coordinators were recorded, with the help of simultaneous text annotations. The interviews were transcribed and analyzed, compared to the text of the simultaneous annotations and organized for the analysis.

Participants were identified to ensure their anonymity, according to the following abbreviations: Interview with A Service Coordinator (ECA), Focal Group with Service Preceptors A (GFPA), Focal Group with Service A Residents (GFRA), and so on for all participants.

The option for data analysis was content analysis[9], which works on the meaning of speech, taking into account the meanings (content), form and distribution of these contents (formal indexes and co-occurrence analysis). We followed the steps of pre-analysis, material exploration and treatment of results, inference and interpretation. From the readings, reflections and data analysis, they were grouped into two thematic categories, of which, in this article, are presented as: "the evaluation of the resident physician from the points of view of the different actors involved". The analytical scheme is shown in figure 1.

The research was approved by ethics committee in research with human beings, with CAAE: 56350616.9.0000.5580 and opinion Nº 1.677.860. All interviewees who participated in the research signed the Free and Informed Consent Term (TCLE).

RESULTS

The evaluation of the resident physician from the point of view of the different involved actors

The preceptors supervise the activities of the residents in an intermittent way, performing visits according to the scale of division of tasks, and according to their clinical subspecialty, mainly in the follow-up of outpatient activities. Basically, in both services, there is a weekly meeting of preceptors and residents in theoretical activities:

> I visit the infirmary on tuesday and thursday morning and thursday afternoon I have the general meeting, which is the "great visit". [...] Mine is daily supervision in the ICU, there is always a resident visiting, this in all months of the year, there. [...] Clinical meeting on monday and wednesday, thursday afternoon and friday morning outpatient clinic, friday afternoon I have class. [...] Visit to the infirmary saturday morning, monday and wednsday outpatient clinic, and "great visit" on thursday [...] (GFPA).

Initially, it is noticed that in one of the services there is no clarity of the routine of the preceptors in relation to the role of supervisors of the clinical practice. The focus group demonstrates this.

> For me it is infirary, the clinic is more complicated, being a position of mine, but the infirmary always has new cases. [...] My preference is also an infirmary, where it is possible to discuss the cases, because the patients who are hospitalized are very ill […] (GFPB).

Regarding the way the resident physician is evaluated, which would include the existence of formal evaluation instruments, a wide knowledge about the methods of evaluation, their frequency and the return of the preceptor

regarding their evolution, the testimonies in the focus groups show as convergent aspects: the existence of theoretical evidence, being two per year in one of the services and quarterly in another, added to the subjective evaluation, which includes interpersonal relationship, responsibility, acquired knowledge, attendance and interest, in one of the services. While in the other service the residents do not know the evaluation questions and mention the evaluation of the day-to-day.

> [...] subjective evaluation, [...] four subjective and one theoretical. [...] notes are divided into interpersonal relationships, responsibility, acquired knowledge, attendance and interest. [...] As for these grades, we are advised that they are already in Coreme for us to sign, but we do not know how we were evaluated, nor who evaluated us. [...] In the theoretical part we are evaluated only twice during the year, objectively. [...] We know you have the grade and they just let us know that we should sign the grade. [...] they do not know how to inform us (administrative staff) how the grades are given and who gave us the grade [...] (GFRA).

> [...] written tests and through day-to-day knowledge, being daily evaluations of the preceptory. [...] There is feedback mainly after presentations in class, after case discussions, there is feedback on how the evolution is over the months. [...] through theoretical and written tests evidence and constantly presentations in class, there is feedback from what we have been positive and negative [...] the subjective, for me, it is a little "obscure" what is evaluated. I know there is, but I do not know exactly how it is done, in feedback as well, being better in the objective part than in the subjective part ... They do not tell us what we need to improve or what we need to evolve (GFRB).

The discourse reveals that both groups of residents do not know how they are assessed, that is, they do not receive feedback on how they are evaluated. One of the services receives the result of the theoretical notes through the secretariat of the program, but both do not obtain return of the preceptory. In the same way, they mention receiving grade from the preceptors even though they are not under direct supervision of them.

On the other hand, in a different way, one of the services mentions the return of the evaluators, mainly after the theoretical activities, in the case discussions and presentations of subjects. However, without a formal evaluation tool, it is also performed subjectively and verbally. Residents report receiving no return on what they need to improve.

The preceptors agree with the lack of a formal evaluation instrument, which is both subjective and objective, that the disclosure of the grades occurs through the program secretariat, and with the subjectivity of the evaluation:

> The grades are given the way they think is most appropriate, but we do not have an instrument. [...] There are five items of which we should score. [...] They receive this score and it is published in Coreme. [...] We have an objective trimestral evaluation. [...] evaluation coming from all preceptors, we evaluated punctuality, commitment, knowledge, resolutiveness, posture (GFPA).

> There is no objective evaluation, such as written or unwritten. [...] The evaluation is in the day-to-day, it is in the discussion of the cases [...] I think that we do not evaluate the resident. There is no script, no intrument [...] I think the coordinator does an assessment (GFPB).

In one of the institutions, the preceptors do not know how it occurs and if the objective evaluation is performed. They mention not evaluating the resident and report the lack of a script or a formal evaluation instrument. In a divergent way, for the coordination, the evaluation is taking place appropriately, with organization and planning, in one of the institutions. For the other, it still needs to improve the interaction with the preceptors. It is recognized that in both services there is no tool that assists in subjective evaluation.

> We evaluated as recommended by the CNRM, a trimestral objective evaluation, all the preceptors who were in contact with the residents give a subjective grade, mainly evaluating five items, such as responsibility, interest, knowledge acquired, attendance and relationship [...]. We also do an annual mandatory assessment, a multiple-choice test, all residents do, and this annual grade is added to the other four subjective, so an average of these five grades is made and the resident must score a minimum of 70 to pass (ECA).

> [...] theoretical assessment every three months, multiple choice plus a subjective evaluation, which is added to this theoretical test, so far it is

> being done by me, we can improve this practical assessment, thus uniting all the preceptors. [...] I have nothing formalized about this evaluation, it is a subjective assessment, there is nothing written regarding the items that are evaluated, it is not made available to the residents themselves. [...] assiduity of the residents, their presence and their arrival times, and beyond their daily life and their theoretical knowledge (ECB).

As for the assessment of the acquisition of specific skills, residents do not realize how they are evaluated, they report not knowing how this assessment occurs.

> I think we are not evaluated [...] They are never with us, so they do not know if we are learning to perform the techniques. [...] We enter the medical residence looking for someone who is there to show us the way we should go and tell us what to avoid. It is the sub-understanding that we know how to do things. [...] It is often R2 who teaches R1 (GFRA).

> [...] it is more informal, we feel more about the confidence of the preceptor rather than a proper assessment (GFRB).

> Reproduction capacity. Practical and theoretical knowledge. [...] The practice we teach, but I believe they are not going to get the theory (GFPA).

> Specifically, we do not have a north and this north of determining the specific skills is fundamental in the technical evaluation. [...] And this is where the importance of nurses comes in, where nurses can communicate if the resident is participating and fulfilling their duties (GFPB).

Instead, preceptors expect residents who already have specific skills for clinical practice and complement those skills by theoretically seeking to enhance their skills. Moreover, they transfer responsibility for evaluation to nurses, who are expected to report when the resident does not meet job expectations.

In addition, we tried to understand how the values and attitudes are approached from practical situations lived, and approach of ethical issues. While in one of the institutions residents believe that the issue is addressed only in situations of conflict, in the other, they believe that the topic is approached, discussed daily, mainly in situations that involve professional posture towards patients and family, personalpresentation, patient approach, when to requestexams or not to, issues of doctor-patient relationship and positioning facing the terminal patient.

> In conflicting situations, yes. But not on a day-to-day basis (GFRA).

> This is discussed daily. Positioning in front of the patients, the conversation with the relatives, the good relationship, the presentation, we receive instructions from the preceptors every day about this. Regarding the ethical aspect as well. [...] but the question of posture, question of examinations, when to ask or not, when to request exams without patient awareness is addressed, I think that all of this goes into the ethics part (GFRB).

> I think I should talk to the resident personally with the patient and then call the family member and teach this attitude to the resident, to have a sense of what to talk, how to talk and who to speak to (GFPA).

Reaffirming attitudes and behaviors regarding to evaluation, while one of the services believes that this evaluation exists, but does not know how it is performed, in addition to believing that only the negative points are evaluated, in the other, the residents do not feel valued for this aspect. They perceive that assiduity, punctuality, doctor-patient relationship are items that count, but they think that the evaluation is informal.

> We believe so, but we do not know how. [...] We are never told whether what we do is right or wrong [...] We have had negative feedback from assessment and behavior, but not from individual level (GFRA).

> Are evaluated informally, we do not have a checklist, but assiduity, punctuality, doctor-patient relationship is addressed (GFRB).

Corroborating the perception of the residents, the preceptors imply that this evaluation is done through information obtained with third parties and not the evaluation performed directly by the preceptor that accompanies the practice.

> [...] are evaluated by the feedback, that is what comes to us, either by complaints, compliments, both from the nursing team, patients, interns, students and between them.

> [...] often interns tells us how the residents are going, if they do things right. The resident physician is assessed from all angles and manners (GFPA).

As for the attribution of value to behaviors and attitudes, compared to the acquisition of knowledge and technical skills, to what extent one dimension influences the other, it was

obtained that the empathy between preceptor and resident is preponderant on the acquisition of skills, behavior and attitudes. They believe that the attitudes and behavior dimension can stand out in a worse judgment regarding clinical and technical skills.

> I think that even more than behavior, what counts is your relationship with the preceptors [...] but if you are not so close to your preceptor, you will get a worse grade. [...] if there is empathy between the resident and the preceptor, the grade will be good (GFRA).

> The physician is a set of both technical and personal knowledge. I believe that if he trembles in one of these aspects ends up having a medium evaluation or, if he is very good at one and very bad at another, he ends up having a very large standard deviation than a more homogeneous person. [...]. I also agree, many times the physician can hit 90%, be an excellent professional, but the behavior and attitude can harm(GFRB).

The preceptors of both services agree that posture, relationship, moral ability, respect for the patient, and responsibility are more important than technical knowledge.

> [...] more practicable you have less knowledge and have more posture. [...] Knowledge you acquire for the rest of your life and throughout the training. [...] but the about relationship with colleagues, responsibility, we have perceived immature behaviors (GFPA).

> [...] more important is not technical skill, but a moral skill, respect for patients, care for them. [...] Knowledge and clinical skill is not the main factor for a person to be good, specially nowadays, of pressure, of relationship, ethics, absence of relationship, if the person is not clever and do not be careful about this aspect, he/she can "get screwed" (GFPB).

On the other hand, the statement that less knowledge can be compensated for by an ethical position leads to reflections. Ethics, morals, respect, humanistic attitude are important, but not to the detriment of technical-scientific knowledge, it is necessary to establish a relationship of harmony between knowledge in the construction of the identity of these subjects.

DISCUSSION

Presidential Decree No. 7,562[5: 7-8], article 18, fourth paragraph, first subsection, presents characteristics of the pedagogical project of the medical residence: "informing the number of residents, general and specific objectives, program content and other pertinent academic elements, including evaluation methodology". In contrast to what is defined by the legislation, both programs do not describe the evaluation methodology in their pedagogical projects. Also, it is perceived that the teachers do not know how the evaluation is carried out in the program, mentioning it as subjective, which in this case represents informality and absence of clear criteria and instruments known by all, except for the objective evaluation recommended by the decree mentioned.

The difficulty found in evaluating residents in this research may be related to the very concept of evaluation[10], a difficult and complex act, since it involves culturally established ways of acting, implying comparisons, classifications, selection. This logical thinking needs to be reversed for educational, diagnostic, and procedural evaluation in order to guarantee learning[3]. In this study, we identified the belief that evaluation that is not measured by numbers is subjective. Thus, establishing criteria makes the rules explicit to substantiate a judgment. Pre-negotiated evaluation criteria allow the teacher to monitor not only the activity, but the students' learning, identifying the construction of the skills.

Among all the roles of the preceptor, it is the function of evaluating the resident in the moral and technical questions of professional practice, enabling development feedback and demonstrating whether the physician in training is taking the expected path. It is defined as the action of the preceptor in its fullness, to act daily as a physician and educator, in the interrelation with patients and residents, worrying about technical and ethical training and offering constant feedbacks to residents[7].

Study on the preceptory in medical residency addressed the lack of pedagogical preparation reflected in the practice of preceptors. This lack influences the competences of the preceptor, since it is necessary to appropriate the teaching-learning process with the resident[8]. This finding is consistent with the reality studied, since none of the professionals involved in the training of residents have the necessary pedagogical

preparation and mentioned in the legislation.

In addition, it is necessary to work with the previous knowledge of the student, to adopt as focus of teaching from the activity, the production process and the product, stimulating the execution of certain tasks, under supervision of the quantity and quality of this work, passing through the focus from learning to performing the task, to reaching the focus on the perception of the whole process by the one who is learning, with special attention to the return to the student, the whole process and the purpose of the task[2].

Different from the Brazilian reality, international studies present evaluation tools in the training of the resident. In the United States, the adoption of a mentor in the practice of a profession is usually a daily practice and studies on the adoption of a mentor by the resident in a training program are developed[11], a model that national residency programs could adopt, qualifying the training process.

Another example is the adoption of problematizing pedagogy in residency of internal medicine, in the outpatient clinic practice, that compared the residents in formation under this methodology, with the others of the traditional curriculum. They concluded that the adoption of the methodology was successful, with a focus on learning in patient care at the outpatient clinic[12]. This is a proposal of differentiated training in medical residency that could contribute to the teaching-learning process in our reality.

In another study, a residence program was evaluated in which a professional development program with a coach was implemented. This program included the developed curriculum, the interrelationship between advisor-student and the evaluation metrics. The dimensions assessed at the meetings included participation, program and professional activities, burnout syndrome, ability to deal with difficulties and communication between counselors and students, which was well evaluated[13].

Study on the development of a tool for evaluating the resident physician of a US service, to improve the development of the resident physician's competences, through the measurement of quantitative and qualitative indicators, with each exchange of learning environment, in which both the service team and patients evaluated their performance on an online dashboard platform, which enabled them to know if they achieved the expected goals and aspects they needed to improve[14]. This is a possibility that could be implemented in the residence services of the study for feedback to both residents and preceptors.

Regarding the work of the preceptor, a study[8] to understand the work agenda and how the attributions of the preceptor was perceived, showed that in the programs studied, an unorganized work schedule produced excessive demands of work. There was a lack of conceptual appropriation in relation to the pedagogical discussion, which has repercussions in practice as a preceptor. This fact is similar to that found in this research, since the absence of pedagogical training influences the evaluation of the residents.

The role of the preceptor is mentioned as essential to guide, support, teach and share experiences that improve clinical competence and help the resident to adapt to the practice of the profession that is constantly changing. Its main function is to teach the clinician, through formal instructions, with objectives and goals, which includes formal evaluations as part of the preceptor's work[2]. Different from that found in the research, because the preceptors do not have an evaluation methodology, mentioning it as subjective. For residents it is also not clear how it occurs.

Therefore, it is necessary to establish methodological proposals that use evaluation tools. Concepts of medical training for student learning encompass the strategies used in the solution of clinical problems, which depend on the difficulty found and the knowledge acquired, whose conclusions will spare this knowledge and the strength of the evidence. In the clinical encounter, the professional constructs questions and weaves answers that lead in a certain direction[2].

In this way, medical education needs to stimulate thought, critical reading, the clear and forceful expression of ideas and opinions and the solution of real problems. In this environment, the resident observes the preceptors, taking them as models of technical skill and knowledge and mirror of behaviors and attitudes, in the formation of professional identity. Thus, the first step in the path of teaching-learning in the

medical residence is to explain what is to be understood and what the learner should be able to do with what he has learned, leaving the objectives of learning clear[2].

To evaluate means to obtain information that will help in the decision making, it is necessary that the planning and execution of the evaluation consider its multiple purposes, to reinforce the learning (formative evaluation). Focus should not only be on acquired knowledge (cognitive skills) but also on the psychomotor and affective domains. In the current Brazilian scenario of the health professions, the exclusive focus on cognitive evaluation prevails, favoring the summative function, rather than formative[15], which was evident in the results of this research.

Evaluation study with indicators to evaluate the teaching-learning process in the area of individual care, contemplated the performance of clinical history, physical examination and clinical reasoning, giving students the opportunity to perform care in the perspective of integrality[16].

In this research, it was evidenced that there is a difficulty in giving a feedback to students for their evaluation, which seems to be because the methods used for both preceptors and residents are not clear. This way, when there is no method, there is no evaluation. In addition, feedback to students, when it happens, is only of the formal objective evaluation (summative), demonstrating the inexistence of the formative evaluation.

Feedback to student professionals is one of the main components of formative assessment and regulates the teaching-learning process, continuously providing information so that students perceive whether they are distant or close to the desired objectives. Thus, the student commits himself to the effort necessary to reduce the distance between what he knows and what he can do, between the current level of learning and that desired[17].

Still, in the dimension of evaluation of ethical and attitudinal values, whose participants do not know how this evaluation occurs, it would be expected that the resident could acquire increasing levels of autonomy, for such, there is a need of the preceptor's feedback in order to build his knowledge and achieve the goals that are expected in the learning process. Study[18] discusses that the preceptor develops the skill in relation to teaching-learning dynamics by tries and error, which results in different pedagogical practices among preceptors of the same residence program.

Another aspect that emerges from the speeches is the poorly democratic environment regarding the evaluation of residents, because the grades are informed through the program secretariat, without direct contact with the evaluators so that the students know exactly where they are not achieving their goals. The more authoritarian a teaching environment is and less participative, the less will be the capacity for dialogue and the development of autonomy. More democratic spaces favor reflections on attitudes, rules and produce consensus, which lead to autonomous behavior, whose participation of the preceptor is central. The authors[18] mention that this responsibility for the moral and ethical formation of the resident is a difficulty for the preceptors, like the speeches of this research. Preceptors tend to perform negative feedbacks, which do not promote the subjects' autonomy, when problem situations should be identified and problematized in the preceptors/residents relationship[18].

FINAL CONSIDERATIONS

The evaluation in the medical clinic residency programs, in relation to the theoretical possibilities (diagnostic, formative, procedural and summative) and the return given to the resident physicians, as well as the use of instruments to evaluate the progression of the students throughout the process of training was not identified, only the one that occurs at the end of a training period, as determined by the standardization. Still, there is no clarity regarding the subjective evaluation, due to the lack of evaluation tools.

Without pretending to exhaust the theme, the study proposes to initiate a discussion that can foster change. This reality about the evaluation in residency programs in medical clinics has shown concern. It requires discussions about changes in its operation, as in other countries, with the adoption of clear criteria for all those involved.

It was noticed that there is a need to carry out

more studies in order to cover the national reality and to see if this is a recurring problem in this scenario, including other methodologies other than the qualitative one, to enlighten the question and to allow reflection that induces the change in the formation and evaluation of this type of education.

DIFERENTES PONTOS DE VISTA NA AVALIAÇÃO DO MÉDICO RESIDENTE EM PROGRAMAS DE CLÍNICA MÉDICA

RESUMO

Introdução: Este estudo enfoca a avaliação do médico residente em seu processo de formação profissional. Objetivo: compreender o processo de avaliação do médico residente em programas de clínica médica, sob o olhar dos distintos atores. **Métodos**: Pesquisa qualitativa, descritiva, desenvolvida em dois programas de residência em clínica médica, com os coordenadores dos dois programas, oito preceptores e15 médicos residentes, totalizando 21 participantes. Coleta de dados com grupo focal e entrevistas gravadas, analisadas por meio de análise de conteúdo, em duas categorias temáticas. Apresenta-se nesse artigo o tema "a avaliação do médico residente sob os pontos de vista dos diferentes atores envolvidos no processo de avaliação". **Resultados**: Encontrou-se disparidade na percepção da avaliação entre os diferentes atores, subjetividade na avaliação, inexistência de regras claras e de conhecimento de todos, remetendo a fragilidade no processo avaliativo. **Considerações Finais:** Recomenda-se adotar na formação em residência médica, estratégias de avaliação estruturadas e que permitam aos envolvidos conhecer o processo avaliativo.

Palavras-chave: Avaliação educacional. Avaliação de desempenho profissional. Capacitação profissional. Internato e residência.

DIFERENTES PUNTOS DE VISTA EN LA EVALUACIÓN DEL MÉDICO RESIDENTE EN PROGRAMAS DE CLÍNICA MÉDICA

RESUMEN

Introducción: Este estudio enfoca la evaluación del médico residente en su proceso de formación profesional. Objetivo: comprender el proceso de evaluación del médico residente en programas de clínica médica, bajo la perspectiva de los distintos sujetos. **Métodos:** Investigación cualitativa, descriptiva, desarrollada en dos programas de residencia en clínica médica, con los coordinadores de los dos programas, ocho preceptores y 15 médicos residentes, totalizando 21 participantes. Recolección de los datos con grupo focal y entrevistas grabadas, analizados por medio de análisis de contenido, en dos categorías temáticas. Se presenta en este artículo el tema "la evaluación del médico residente bajo los puntos de vista de los diferentes sujetos involucrados en el proceso de evaluación". **Resultados:** Se encontró disparidad en la percepción de la evaluación entre los diferentes sujetos, subjetividad en la evaluación, inexistencia de normas claras y de conocimiento de todos, mostrando la fragilidad en el proceso evaluativo. **Consideraciones Finales:** Se recomienda adoptar en la formación en residencia médica, estrategias de evaluación estructuradas y que permitan a los involucrados conocer el proceso evaluativo.

Palabras clave: Evaluación educacional. Evaluación de desempeño profesional. Capacitación profesional. Internado y residencia.

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