Learning and Teaching in Clinical Contexts
A Practical Guide
Learning and Teaching in Clinical Contexts
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Clare Delany is known nationally and internationally for research and practice in health professional ethics, clinical reasoning, critical reflection, resilience for clinical learning and translation of educational theory into health workplace environments. Her work has mostly centred on physiotherapy; however, she reaches beyond that profession to teach and research in health professional education and higher education more broadly. Clare is Chair of the University of Melbourne ’Education, Fine Arts, Music and Business’ Human Research Ethics Committee and has served as Vice President of the Physiotherapists’ Registration Board in Victoria and Chair of the Australian Physiotherapy National Professional Standards Panel. Clare is author or co-author of more than 90 publications in peer-reviewed journals and has co-edited two books: *Clinical Education in the Health Professions* and most recently *When Doctors and Parents Disagree: Ethics, Paediatrics and the Zone of Parental Discretion*. Clare’s research expertise is in the area of qualitative methodology and methods and this is applied across broad subject areas of clinical ethics, clinical education and paediatric bioethics. At the Department of Medical Education, The University of Melbourne, Clare is responsible for coordination of research higher degrees and the masters year of the EXCITE (Excellence in Clinical Teaching) program. Clare is also a clinical ethicist at the Royal Children’s Hospital Children’s Bioethics Centre in Melbourne. This role involves conducting clinical ethics consultations, education and research in paediatric bioethics.

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We hope you enjoy and learn from this book as much as we have enjoyed and learned from editing it.

Clare Delany and Elizabeth Molloy
Introduction

Underperformance in clinical education is a significant challenge. Underperformance is more than the routine mistakes and errors associated with learning. It is persistent, and concerns those learners who do not work at the expected level of competency for an extended period of time. These learners are at risk of failing clinical placements.

Much of the published literature overlooks the phase where students are at risk, instead focusing on the point of failure and beyond. The ‘remediation’ literature (Cleland et al., 2013) considers ways to address gaps in knowledge skills and attitudes, generally after learners actually fail. It often takes place outside of the immediate clinical education environment. Equally, an extensive body of work explores the moment of failure, particularly when clinical educators ‘fail to fail’ learners whom they know do not meet the required competency criteria. However, decisions to fail and remediation generally come at the end of the placement or after. By this time, it is too late for the learner to learn from the opportunities within that particular placement environment.

This chapter takes an alternative view. It offers strategies for working with underperformance within the clinical placement. The focus is on the educational processes that assist both the learner and the clinical supervisor to make the best out of the situation at hand. It asks the question: How can learners who underperform be assisted to build their capacities?
The challenge of underperformance for clinical educators

Learners who are at risk of failing clinical placements have enormous impact on clinical educators’ workload and stress levels, irrespective of profession (Health Workforce Australia, 2010). This may be because clinical educators report failing students as extremely challenging, with a high negative emotional impact. In many instances, clinical educators feel as though they themselves are insufficient (Salm et al., 2016). For instance, a nurse preceptor describes emotions after failing a student: ‘I felt like I killed somebody. I killed somebody’s career’ (Hrobsky & Kersbergen, 2002, p 552). Qualitative studies note the complexity of emotion that clinical educators can experience while assisting students who underperform (Luhanga et al., 2008; Salm et al., 2016). At an extreme, clinical supervisors may also have concerns about legal action or bullying accusations. These emotions reflect the tensions of the clinical education environment.

Clinical education requires the supervisor to take on many roles with competing responsibilities, such as teaching, assessment and patient care (Bearman et al., 2012). The tensions between these roles are exacerbated when students underperform. Often, educators are stretched to provide appropriate patient care while simultaneously allocating meaningful tasks to students who have not yet reached an expected level of competency. Likewise, it may be difficult to provide mentorship to students, while simultaneously assessing them as being below expectations. Underperformance also increases the many bureaucratic requirements of liaising with academic institutions, complying with the competency standards of the profession, and ensuring that the safety measures of the workplace are met. All of this must be managed in a busy work environment, where time and other resources are often very scarce. Moreover, clinical supervisors are frequently placed in this challenging supervisory situation with limited professional development in educational skills (Bearman et al., 2017).

In a study of physiotherapy clinical supervisors, Bearman and colleagues (2012) noted that the supervisors had limited strategies for managing underperformance and coined the term ‘more more more’ to describe their general approach. The clinical supervisors gave more of the same feedback, more of the same activities, and more oversight to learners who were underperforming. It is noteworthy that, for the most part, they didn’t do anything differently. This is common across different professional contexts: Cleland and colleagues’ (2013) systematic review of remediation in health professional education suggests that remediation is likewise ‘more of the same’ generally focused on ‘getting’ the learner over the line. They critique remediations as ‘tailored to improve performance to the standard required to pass a re-sit or re-take rather than to support the development of effective lifelong learning skills’ (Cleland et al., 2013, p 247). This underpins the point: clinical educators lack educational strategies to develop learners; they are concerned with how the learner can pass, rather than educating the learner on how they can succeed in the future. This chapter seeks to address this gap.

This chapter provides practical strategies for working with underperformance, grounded in educational theory. First, we discuss how clinical educators can identify underperformance. This is strongly grounded in the clinical educator’s perspective. Next, we explore two specific theories that provide means of understanding the learners’ perspectives in underperformance. Throughout this chapter, we suggest that appreciating the learner’s perspective is essential to supporting the learner to develop the necessary skills both to pass the placement and to manage their own future learning. Finally, we draw from both theory and practice to outline strategies for working with underperformance, which focus on developing the learner and supporting the supervisor.

In order to explore these ideas, we use two case studies. The first is set in a postgraduate specialist medical training environment. The second concerns undergraduate occupational therapy. From a clinical education perspective, the set-up of the placement from commencement is significant in how underperformance is identified and managed. For this reason, we start our case studies, before the underperformance becomes apparent.

Case study 17.1: Anaesthetic training — introducing Kate and Antoine

Kate is supervisor of training in anaesthesia in a tertiary hospital. She is responsible for the junior anaesthetic trainees in her hospital, who face significant challenges as their prior training has been in suburban and country hospitals, and this is their first placement in a tertiary hospital. Although
Identifying underperformance is a different task to helping learners overcome underperformance, although clinical educators often do both simultaneously. While based on interactions with the learner, identifying underperformance is primarily the work of the clinical educator. This is in contrast to underperformance, where the strategies need to be more learner-centred so that the work belongs mostly to the learner, with the clinical educator in support.

In identifying underperformance, Steinert (2013) suggests that there are three areas of performance that are worth interrogating: knowledge, skills and attitudes. She also notes: ‘teachers often assume that it is the learner who has the problem’ (Steinert, 2013, p e1037). As a first step, Steinert suggests identifying whose ‘problem’ is prompting concerns: does the problem belong to the learner, the teacher or the system? Contemplating this type of question can be beneficial when grappling with a situation that is ambiguous and potentially challenging. For example, in case study 17.2 Ethan hasn’t spent sufficient time observing Sarah. This is a ‘teacher problem’. Another ‘teacher problem’ can result from clinical educators finding
it easier to work with people they identify with; for example, sharing the same cultural background, class, gender and so on. It’s important to be aware of the potential for these unconscious preferences. In clinical education, ‘system problems’ often relate to a lack of opportunity for practice. Another common system issue is a challenging or toxic practice environment, in which all learners will struggle. It’s worth noting that, while asking ‘who’s problem?’ is a valuable first question, it’s not always easy to answer. This is partially because systems problems and teacher problems are exacerbated when a learner persistently underperforms.

So how can clinical educators know whether underperformance is more significant than just the normal errors and challenges of progression? Paice and Orton (2004) suggest looking for ‘flags’ that indicate a trainee is having difficulties. These ‘flags’ are signs of a potential problem that is more significant than usual, and include:

- **poor clinical performance**, including inadequate note-taking, difficulty in recognising urgency associated with a particular clinical situation, and so on;
- **unexplained absences**, which may be particularly related to broader issues, including bullying or depression;
- **rigidity**, including self-righteousness and an inability to accept responsibility for actions;
- **outbursts**, which may be strongly associated with stress;
- **failure to gain the trust of others**, which may also be related to systems issues, such as bullying of the trainee.

Both Steinert (2013) and Paice and Orton (2004) suggest identifying situations that are of concern, rather than focusing on the trainee as a ‘problem’. This is a valuable approach, because, as Hodges and Lingard (2012) note, competency is not a fixed notion nor a fixed quantity. A person is not inherently incompetent or competent. Indeed, we all progress from mostly incompetent to mostly competent as we move from novice to expert. As future professionals who will take responsibility for their future conduct and learning throughout their career, learners should understand that competency (or incompetency) is not a stable personality trait, and that individuals can learn to develop. Thus, we also emphasise that the focus on the situation, not the learner, is appropriate. As a corollary, it is worth being careful about how underperformance labels are articulated and applied. We suggest shifting from the terms ‘underperformers’, ‘struggling students’, ‘poorly performing learners’ and ‘problem students’, and instead referring to ‘students or trainees who underperform’. This acknowledges the problematic situation without providing a sense that it is permanent or personal.

Identifying underperformance is the easier part of the equation. Helping the learner to improve their performance is a knottier problem for most clinical educators, particularly when it is not a matter of more practice or more knowledge. Steinert (2013) notes that clinical educators often find attitudinal difficulties particularly difficult to manage. This is where educational theory can assist.

**Case study 17.1 (continued): Anaesthesia training — identifying underperformance**

Almost four weeks into the placement, Kate is pulled aside in the corridor by the anaesthetic charge nurse. He tells her that his staff are worried about Antoine. They have told him that they think he is indecisive, lacks confidence, that he is slow in preparing for cases after-hours, and doesn’t clearly tell them what he wants from them before or during cases. A few of them have started to notify the other registrar who is on overnight with other duties when Antoine is doing a case, so they are around, ‘just in case’.

Kate thanks her colleague, and tells him that she will monitor the situation. She knows that not every issue that is flagged to her will turn out to be significant. Sometimes, a trainee might not get along with one or two people, or have had a ‘bad day’, as anyone’s performance can fluctuate.

Later that afternoon, Kate sees a colleague, Paul, who worked with Antoine the previous week. She asks Paul how he has found working with Antoine. Paul says that Antoine was not as ‘sharp’ as he expected the new trainees to be. He seemed unsure of himself and unprepared for the cases.
Case study 17.2 (continued): Occupational therapy — identifying underperformance

On Monday afternoon, Ethan observes Sarah with Mrs Peirce, an 86-year-old lady who was admitted over the weekend after a fall at home. This is Mrs Peirce’s initial assessment and first contact with anyone from the allied health team since she arrived. The cause of her fall is still under investigation, with notes from the general medicine team stating ‘IMP: ?AF for Cardiol r/v.’ After reading the notes, Sarah enters Mrs Peirce’s room to find her attached to an electrocardiogram (ECG), oxygen therapy, and pulse oximeter. Sarah introduces herself and proceeds to gather a detailed history from Mrs Peirce. Ethan is pleasantly surprised with Sarah’s performance, and feels comfortable leaving Sarah to complete the rest of the assessment while he answers a page from the physiotherapist.

Some minutes pass. While on the phone, Ethan witnesses Sarah and Mrs Peirce walking with no walking aids or attachments towards the corridor. Sarah is striding half a metre in front of Mrs Peirce, leading her to the bathroom to assess her self-care performance. Ethan notices Mrs Peirce slow down, reach for the wall and (luckily) find a seat on a wheelchair that has been left in the corridor. Sarah takes a little while to realise what has happened, and inquires as to what is wrong. Mrs Peirce states she is ‘feeling a bit dizzy and would like to return to bed’. Ethan steps in to check Mrs Peirce’s vital signs by applying the portable pulse oximeter. Her oxygen is at 89%; however, the probe is struggling to find a trace. Mrs Peirce is still dizzy as Ethan wheels her back to her bed, where her ECG and oxygen are reattached. Ethan immediately alerts the nursing staff to take over providing essential care to Mrs Peirce, and takes Sarah aside. As it is nearing the end of the day, Ethan suggests that Sarah write in Mrs Peirce’s notes, and that they meet in the morning to have a chat about what happened.

Theories which inform working with underperformance

We propose exploring underperformance through the lens of two very different but complementary theories: ‘communities of practice’ and ‘self-determination theory’. Neither of these are explicitly about underperformance, but we have chosen these theories to encourage educators to think deeply about the underperformance situations they encounter from different perspectives. The aim is to shift how clinical educators conceptualise and manage underperformance. These theories draw from very different traditions. One focuses on the broader social environment of the learner; the other focuses on individual internal processes.

Learning as social participation: communities of practice

Conceptualising learning as a social act may help explain why underperformance presents so many challenges. One of the best-known theories of social learning is ‘communities of practice’ (Lave & Wenger, 1991). This grew from Lave and Wenger’s study of apprenticeship, and how apprentices moved from the ‘periphery’
of a practice to being an ‘old-timer’ at the centre of activity. Wenger (1998) suggests that there are three necessary elements to a community of practice:

- mutual engagement;
- joint enterprise;
- shared repertoire.

**Mutual engagement**

Workers interact with each other, and these social interactions are central to the community of practice itself. The community is formed by participation. In this way, the novice healthcare worker learns not just through observing, but also through interaction and joint tasks, buttressed by social interactions. This may explain why clinical supervisors can find disinterested learner attitudes so challenging: if they refuse to participate, they cannot learn.

**Joint enterprise**

The workers must have shared purposeful activities. In the case of clinical education, this is the general work of the department, unit or practice. The enterprise is constantly emerging through ‘negotiation’, which forms evolving practices rather than static rules. This evolution is constantly ‘negotiated’ by the members of the community, and necessarily entails ‘mutual accountability’. This underlines how useful it is to make the tacit ‘ways things are done around here’ as explicit as possible for novices.

**Shared repertoire**

There is a set of common tools for a community of practice. These include the language of the clinical environment, as well as the daily practices: a ward round, conducting ‘obs’ (observations), taking a history. A novice often lacks the shared repertoire, and part of the work of learning in a clinical environment is coming to enact these common tools through participating in the work of the unit. These three aspects — mutual engagement, joint enterprise and shared repertoire — are interlinked, and by their nature cannot be reduced from the sum of their parts. In a nutshell, learning in a community of practice can only occur through experiencing it.

**Other implications of communities of practice theory**

Communities of practice theory suggests that novices craft an inbound trajectory through the community. They shift from the inexperienced and inexpert periphery into ‘identities of participation’. Wenger (1998) distinguishes ‘peripherality’ of novices from ‘marginality’, where there is no inbound trajectory to take the individual more deeply into the community.

‘Marginality’ is an identity of non-participation. Considered in this way, performance issues can position an individual on the margins of a community; this is further out than the periphery, because there is no way to work towards ‘full’ participation. Viewed in the context of clinical education, this marginality is more impactful than the failure of the student who does not do well in an academic exam. Even in the circumstances of exam failure, a learner can still participate in student life: attend lectures, study groups. Clinical underperformance means that learners are frequently not allowed to perform certain tasks, and become marginalised from the practice community. This can be an immediate form of social exclusion, and may arouse strong negative emotions, which can impede learning further. Moreover, the very act of investigating underperformance can amplify the sense of marginality.

While communities of practice does not immediately suggest strategies for working with learners, it raises some key ideas: participation is necessary for learning; tacit rules should be made as clear as possible; and social interaction supports bringing learners into the community. In addition, non-participation leads to learners feeling marginalised from their learning environment. We draw from these ideas later in this chapter.

**Critiques of communities of practice theory**

One major critique of ‘communities of practice’ theory is that it does not put enough emphasis on what the learner brings to the community (Fuller et al., 2005). Other theorists, such as Stephen Billett, do highlight the role of the learner. Billett (2014, p 5) notes that ‘… humans are active meaning makers and
this is a degree of policing rather than true help’ (Patel et al., 2015, p 49). Being told once more that you are doing something poorly or being offered the same activity (which you have already failed) again or being burdened with even more oversight are at odds with building feelings of autonomy, as well as further degrading any feelings of competence.

SDT helps frame the core challenge for clinical supervisors: what educational strategies promote autonomy and relatedness, while at the same time sufficiently scaffolding underperformance and ensuring patient safety? The rest of this chapter investigates this question. There is limited research in this area, so these strategies are drawn from diverse bodies of work, some of which are specific to underperformance and some of which are more general.

Case study 17.1 (continued): Anaesthesia training — initial approach to underperformance

In preparation for the meeting, Kate talks to some more of the consultants who have worked with Antoine. She is not reassured. They tell her that Antoine has difficulty integrating the requirements of complex patients and surgery, that he seems under-prepared and reluctant to start complex cases, lacks vigilance, and is reticent to intervene when required. When they meet, Kate is keen to hear Antoine’s side of the story. Antoine says that he has found the placement challenging, and has been working longer and doing extra reading. He remarks there is so much to take into account when deciding what is the right thing to do, but he thinks he is managing okay.

Kate relays the consultants’ concerns. Antoine points out that they haven’t said anything directly to him, and that he expects them to intervene whenever they think it is appropriate, so he hadn’t thought anything was wrong. Kate gives a few specific examples, and explains how each consultant separately had thought his performance might be an exception, but when taken together their reports are consistent and indicate a real issue.

When Kate asks him how he is finding working with the anaesthetic nurses, he says he hasn’t given it much thought; they generally seem happy to do what he tells them to do. Kate tells him that the nurses are concerned when they work with him, and that they are getting the other registrar to stand by when he does a case. Antoine is surprised to hear this, and is concerned what his peers will think.

Next, Kate checks on Antoine’s health and home life. He doesn’t report any issues, and, given she doesn’t have any way to check personally, she decides to take this response at face value.

Kate tells Antoine that the situation as reported to her indicates his performance is below that expected, and that they will need to agree a remediation plan. Antoine is reluctant to acknowledge that this is required, but agrees to cooperate.

Antoine’s roster is changed so that he works with a smaller, select group of consultants whose judgment she trusts, and whom she can rely on to provide specific and honest feedback to Antoine on his performance. She asks them to complete work-based assessments on cases they perceive are appropriately challenging for Antoine, so he will receive useful feedback and she will have a record of his performance and the feedback discussions that take place.

Kate discusses with Antoine the need to articulate his plans to his anaesthetic nurse prior to each case, and to keep them informed of what he is thinking. Kate says she will be asking the nurses to give feedback to her on how he is performing in this area. She organises for Antoine to attend the local simulation centre to help practise prioritisation in decision-making and teamwork. They agree to meet in two and four weeks to review progress.

Case study 17.2 (continued): Occupational therapy — initial approach to underperformance

Ethan prepares some notes for the feedback meeting, and meets Sarah in the meeting room up on the ward the next morning. Despite his preparation, the conversation with Sarah does not quite go to plan. Sarah and Ethan seem to agree that Sarah’s history-taking is a strength of hers. She engaged well with Mrs Peirce and had successfully identified some key occupational performance issues, determined relevant acute occupational therapy goals, and commenced discharge planning. When asked to identify areas that she did not do so well, Sarah answers, ‘Well, not much. She [Mrs Peirce] never made it to the bathroom, so I don’t know if she is safe to go home.’ When Ethan prompts about any other safety issues of concern, and what might have impacted on
Two types of practical strategies assist with underperformance. Firstly, there are general approaches that are valuable for all forms of clinical learning, but particularly necessary for underperformance. We need to outline these first, as they form the foundational platform to build underperformance specific strategies. Secondly, there are strategies specifically designed for learners who underperform. Different types of strategies and how they are used, both generally and specifically with underperformance, are outlined below. The next sections outline these strategies in more detail.

### PRACTICAL TIPS

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### General strategies across the spectrum of performance

#### Learning plan

The first tool of choice at the commencement of a placement is the joint development of a learning plan. The emphasis here is on the joint construction. It is through this upfront investment that ground rules for
the placement are set, the engagement of the learner begins, and an educator–learner relationship is established. In case study 17.1 (anaesthesia), Kate has tools from the accreditation body to assist her in developing this learning plan. Ethan, inexperienced and unsupported, does not have the expertise to develop this from the start. Learning plans allow the learner and the educator to develop goals together for the placement. They allow the learner to declare areas of concern, and for educators to flag transitions that the learner finds difficult. Most of all, they allow the explicit and agreed declaration of standards. This serves as a useful benchmark for later conversations about performance. For example, the presence of explicit standards would be very useful in Ethan’s conversation with Sarah.

Workplace curriculum

The educator allocates tasks to the learner that constitute a workplace curriculum. In a placement experience that goes according to plan, the general notion is that through work the supervisor guides the learner. This allows the learner to complete increasingly difficult tasks and assume greater independence. From an SDT perspective, the learner’s needs for relatedness, competence and autonomy are all met. From a communities of practice perspective, the learner progresses on a trajectory into the community.

Like many clinical educators, Kate and Ethan articulate this curriculum more tacitly than explicitly. They may never consciously consider some of the educational tools at the clinical educator’s disposal. These are well described by Billett (2001), and include:

- role-modelling of the expected standards;
- sequencing of tasks, from those that are easier to those which are more challenging;
- consideration of tasks that are routine (most for students), to those which are non-routine (more important for post-graduates);
- opportunities to learn outside of the workplace environment; for example, reading for knowledge or using simulation for skills development;
- manipulation of levels of responsibility, so that the learner is always working within their zone of challenge;
- explicit articulation of ‘the way things are done around here’ — so that the learner can understand some of the tacit approaches;
- explicit links between the particular situation and other situations — to assist the learner in transferring their learnings to other situations.

In both Ethan’s and Kate’s situations, these tools have not all been employed. Sarah, in particular, would benefit from more exposure to the expectations of practice through role-modelling and articulation ‘of the way things are done around here’. Antoine is clearly being provided with opportunities outside of the workplace, but Kate could be reviewing these with him to ensure they are the right ones. Antoine could also benefit from explicit positive links from his previous rotation to his current one. In these examples, these activities and conversations serve multiple roles. First, they help Sarah and Antoine with the tasks at hand. Secondly, they provide them with the shared repertoire of the community of practice. Finally, they allow Ethan and Kate to facilitate feelings of relatedness (through the building of the relationship), competence (through the exposure of tacit practices) and autonomy (through the investment in them as potential colleagues).

Building relatedness: the educational alliance

As can be seen, the role of the educator–learner relationship in devising a workplace curriculum is significant. Most learners, let alone those who may be underperforming, are in a vulnerable place, as they are on the periphery of the community of practice and have lower feelings of competence due to their novice status. Thinking about the clinical supervision process as an ‘educational alliance’ may assist. Drawing from the psychotherapy notion of the ‘therapeutic alliance’ between a therapist and a patient, the notion here is that the learner’s perception of the relationship between the clinical supervisor and the learner is central to the value of the feedback. As Telio, Ajjawi and Regehr (2015, p 612) note:

… the learner is likely to be actively exploring and testing the supervisor’s commitment to the learning process from the first moment of their first meeting. Almost immediately, the learner will be asking himself or herself questions such as the following: Does this supervisor care about me as a person? Am I present in this person’s mind? Does this supervisor care about my goals in this context? Is he/she trying (and able) to understand where I am starting from and where I want to get to? Does this supervisor have my best
information in their own time. Providing the opportunity to offer suggestions, and genuinely considering these suggestions, promotes feelings of autonomy. When the clinical educator and the learner sit down together to form a remediation plan, it is useful to frame this as an exercise in joint problem-solving. If possible, the plan should provide for some independent practice; this may mean giving learners easier tasks to do without oversight that do not impair patient safety.

In case study 17.2 (occupational therapy), Ethan’s management of Sarah unintentionally removed much of her autonomy. While it is appropriate that she should not be managing patients independently until Ethan is sure that she can do so safely, she can be supported towards a path where she can work safely by herself. While Sarah was told explicitly that what she had done was not right, it may have been difficult for her to have understood what she should have done instead. This is an opportunity for a focused and explicit demonstration of the expected standard. Sometimes things that are very self-evident to experienced clinicians, bewilder novices.

**Relationship management: ‘pause and think’**

As noted, underperformance invokes heavy emotions. This means that a clinical supervisor must be managing their own emotions as much as those of their learner, as they are having to maintain the learner’s motivations. We suggest a very simple practical strategy: ‘pause and think’ at every juncture when the clinical supervisor feels the stress of underperformance. We suggest they ask themselves the following questions before having a feedback conversation or devising a learning plan or considering what to do next:

- **How is your current situation and environment affecting what you are thinking and feeling?** (For example, are there clinical or administrative or staffing issues? What other stresses do you have?)
- **What is the learner’s impact on you?** (For example, is it ‘more more more’? What impact is it having on your feelings of competence, relatedness and autonomy?)
- **What is your impact on the learner?** (For example, what impact are you having on their feelings of competence, relatedness and autonomy?)

Take stock of all these things; it may be that some feedback exchanges must happen right now, and others can be shelved for later. The learner may need space to come to grips with their own situation. Alternatively, it may be that now is the perfect time for a quick discussion in a quiet place.

**Specific feedback strategies**

Feedback is very challenging with underperformance. Most feedback models are designed to take account of deficits, as all learners make errors, and feedback exchanges about the gap between performance and standard are generally par for the course. All models, however, are prone to tokenism. For example, the clinical educator may tokenistically use learner-centred phrasing, but the message is clear: the learner has done something wrong, and the clinical educator is telling them what ought to be done to fix it. This is a common type of message. The problem is that it not only reduces a learner’s sense of competence (a necessary part of coming to grips with underperformance), but also simultaneously impairs the learner’s sense of relatedness and autonomy.

Focusing on building relatedness and autonomy may give learners the intrinsic motivation (and possibly the ‘insight’) to work towards improvement. Whichever feedback model is employed, consider how the feedback exchange can maintain the learner’s sense of relatedness and autonomy. The former is relatively easy. As mentioned earlier, focusing on situations and behaviours rather than personalities can assist. Body language and tone are also important, as these are critical in terms of building a sense of relatedness. Autonomy is more challenging. This is why feedback models often seek the learner’s input into solutions: how can the learner ‘own’ the situation and the way forward? Goal-oriented feedback may prove helpful. In this model of feedback, either before or after the task the clinical supervisor will ask for the learner to nominate a preferred focus for the feedback exchange. This can assist in giving the learner a sense of control.

It is important to have a discussion of alternative pathways to progression; they can and should be provided as real options. Withdrawal or failure is sometimes necessary, and may be important for the learner’s trajectory. Underperformance may be transient and due to external factors; in these circumstances, time away from the clinical environment can be restorative. Kate made attempts to identify whether there are external factors that may have been troubling Antoine, but had no way to confirm his response. We
appreciate these conversations can be difficult for both parties; an educational alliance may help create an environment in which learners/trainees are willing to share this type of information.

**Administration: documentation and referrals**

Documentation is even more critical once underperformance is identified. Underperformance is rarely a single person’s problem; there is usually a broader system involved. Make sure that documentation is exchanged with that broader system: the accrediting body, university or employer. The learner will need to know this, but they can also be informed that this is a common situation and it is for their own benefit as well. Also make sure that the learner is provided with all the assistance that the broader system offers. In particular, mental health supports, disability supports and mentoring are all great resources that can be underutilised. As clinical educators, it can be difficult to remember that the learner is a member of more than one community of practice, and that these other communities may provide appropriate assistance.

**Case study 17.1 (continued): Anaesthesia training — a different approach to underperformance**

In spite of the measures Kate and Antoine agree to, Antoine continues to struggle. He does not seem to take in the feedback he receives, is unsure of himself when working without direct supervision, and is reticent in his dealings with the anaesthetic nurses. He has become reluctant to attend meetings with Kate or the other supervisors, and has had many days absent from work. Kate is worried that all of the extra effort that the department is putting in to help Antoine is not working, so she seeks advice from Richard, a more experienced supervisor who supervised her. Richard asks her what Antoine thinks he needs to do to improve, and she realises she hasn’t really asked him — that they have mostly been telling him where he has failed and what they think he needs to do. Richard points out that in the end, it is Antoine who has to learn, and that their feedback needs to support his confidence and autonomy. She decides to start again by first asking Antoine what he thinks he should do.

It takes some work to convince him, but she meets with Antoine and asks him whether he thinks the remediation plan is working. He doesn’t think so. He feels like he is under a microscope and that whatever he does is wrong, and even though he thinks he knows more about what he is doing and is not overwhelmed anymore, no one seems to notice. He says he’s no longer confident even with work he knows how to do. Kate realises that everyone trying to be helpful and telling Antoine where he is going wrong has not had the effect they had hoped for. When Kate asks him what he thinks he should do, he says he would like to ‘turn back time’ and go back to his previous role, where he was comfortable and competent and felt at home.

Kate organises for Antoine to return to his previous workplace for the next placement, where the staff know him well. Together with the supervisor there, Kate helps Antoine to plan what he can do to regain his confidence and sense of competency through setting tasks to be at right level to challenge his learning within a supportive environment. They also make specific plans that he can practise to better prepare for dealing with the more complex work he will face when he returns. Kate plans in the meantime to try out a new feedback model with her colleagues so that if Antoine does need more help on his return they can do a better job of it.

**Case study 17.2 (continued): Occupational therapy — a different approach to underperformance**

Over morning tea, Ethan takes time to reflect on the feedback meeting with Sarah. He knows it hasn’t gone too well, but is unsure of what other approaches to take. Sarah was unsafe, but telling her about her deficits didn’t seem to have the effect Ethan was after. She doesn’t seem aware that she had areas to improve on, nor is interested in improving. Short of coaching her step-by-step through her next session with Mrs Peirce, or outlining the patient safety items on her assessment tool, Ethan is not sure how to motivate her to change her practice.
Ethan starts to consider the situation from an alternative perspective. He realises that he could have engaged with Sarah in a different way. What is it that motivates Sarah? Reflecting on the time he has spent with her, Ethan acknowledges that he has yet to explore Sarah’s personal goals or what she hopes to achieve at this placement. What are her learning goals? Perhaps Ethan can use yesterday’s example with Mrs Peirce to explore what Sarah hopes to achieve, and outline some strategies to move towards achieving the expected level of performance. Ethan also considers the value of Chloe and Sarah working together in a more collaborative learning approach. He can easily schedule some time for Chloe and Sarah to work together. They could present client cases to each other, and discuss the key things they have learnt. Ethan could prompt them to highlight the key safety aspects of each case, with a view to helping Sarah see the importance and the need to check the safety signs of patients, and to be mindful for potential risks that may occur.

### Failure and its consequences

Successfully working with a learner who is underperforming does not always mean that the learner passes. In our case studies, Ethan and Kate have reworked their plans to take account of Sarah and Antoine’s perspectives, and these changed approaches may well provide them with the opportunity they need to meet the requisite standard. However, there are no guarantees. Failure occurs; learners sometimes do not meet the requirements for a whole host of reasons. Learners may never acknowledge any deficits; there are intractable situations where a learner and a clinical educator’s views never converge — these are but two examples. However, it is not the clinical educator’s responsibility to make the learner pass. Their responsibility is to create a curriculum and environment where learners have an opportunity to succeed. ‘Failure to fail’ has many negative impacts, most notably on patient care, but also on the learner themselves. A practitioner who never feels competent may never feel comfortable in their profession.

### Potential directions for evaluation and research

The area of underperformance is a very open area for further research. There are many potential avenues that could usefully inform both academic understandings and clinical education. Most notably, it would be very helpful to have qualitative and quantitative data that support particular strategies for working with underperformance. Much of the work in this space is drawn from theory and from expert clinical education practice. It would be useful to know what the various impacts of different approaches have on both learners and clinical educators. One particularly interesting area for investigation is the notion of team rather than individual competence.

### Conclusion

Underperformance is a challenging area for clinical educators and learners alike. Failing to meet standards is unpleasant all round. This emotionally negative situation may be compounded by insufficient educational training. This chapter has offered some theoretical insights and practical suggestions. The take-home message can be summarised simply: if you notice yourself saying or doing the same thing over and over again, then it may be time to think differently. Learners need autonomy in order to progress, and the art of clinical education is working out how to give them this in a way that is safe and constructive.

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