

‘Is there a Plan B?’: clinical educators supporting underperforming students in practice settings

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The relationship between supervisors and students in work-based clinical settings is complex, but critical to the appropriate development of the learner. This study investigated the experiences of physiotherapy clinical educators of working with underperforming students, and specifically explored educational strategies used with this subgroup of learners. Findings indicated the cyclical relationship between clinical educator’s stressful experiences of working in multifaceted roles within a clinical environment and their tendencies to provide ‘more more more’ – more of the same strategies, more feedback and supervision, and more of themselves – as their primary approach to supporting underperforming students. The data suggest that clinical educators did not have an alternative (‘Plan B’) if the ‘more more more’ approach did not produce results. We argue that the problem of managing underperforming students is a complex one without easy solutions but a focus on systems changes rather than upon individual students or clinical educators should be considered.

Keywords: work-based learning; clinical supervision; physiotherapy; education; underperformance; remediation; clinical competence

Introduction

The relationship between students and supervisors in work-based placements in health and social care settings is complex but critical to preparation for informed and independent professional practice (Clouder 2009; Kilminster and Jolly 2000; Lefevre 2005). One of the key challenges facing clinical supervisors concerns working with underperforming students. Some of the difficulties associated with this particular subgroup of learners have been well described in many health professions (Cleland, Arnold, and Chesser 2005; Hayes et al. 1999; Hrobsky and Kersbergen 2002) but little has been written regarding how clinical educators support the development of underperforming students within the work setting, or about the theoretical frameworks which might support this process. This study explores the perspectives of clinical educators regarding their experience of, and strategies for, assisting underperforming students within the practice environment.

There are many reasons a health professional student does not reach required performance levels in work-based settings including illness, difficulty in transition

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into clinical practice, skills or knowledge deficits, challenging workplace conditions and difficulties with interpersonal communication (Vaughn, Baker, and Dewitt 1998). Poor performance in clinical environments is not the same as poor academic performance. Miller (1990) argued that 'knowing' is not the same as 'doing'. McGregor's (2007) narrative of an academically successful but clinically failing nursing student provides a qualitative illustration of difficulties encountered by successful students when they enter clinical settings, with its description of anxiety, distrust of supervisors and a 'slow slide into failure'.

Clinical educators, despite their remit to maintain practice standards, sometimes pass underperforming students (Dudek, Marks, and Regehr 2005). Cleland et al. (2008) identified that medical educators' attitudes and beliefs, self-efficacy, skills and knowledge and environmental factors contribute to 'failure to fail' and argued that clinical educators need increased support in their role as assessors. Luhanga, Yonge, and Myrick (2008a, 2008b) argued that nurse preceptors were not adequately prepared for their responsibility as gatekeepers for a profession. They concluded that universities need to provide professional development and support for educators, so they can assess students' fitness to practice.

Few studies of underperformance focus upon clinical educators' strategies when confronted with underperforming students. Luhanga, Yonge, and Myrick (2008c) conducted a qualitative study of strategies used by nursing preceptors with 'unsafe' students. Preceptors reported the use of a range of strategies such as focusing on prevention of errors rather than remediation, early identification of learner deficits, encouragement to practice skills, giving appropriate feedback and seeking assistance from other experienced staff. The health professional literature on strategies for supporting underperforming clinical learners describes models of remediation, typically positioned as an 'after the fact' intervention rather than an *in situ* work-based learning approach. Hauer et al. (2009) published a comprehensive thematic review of remediation literature in medical education. They concluded that there is little quantitative evidence to guide best practices in remediation in health professional education both before and after learners gain qualifications. The authors proposed a practical remediation approach: (1) initial assessment (or screening) using multiple assessment tools to identify deficiencies, (2) diagnosis of problems and development of an individualised learning plan, (3) provision of instruction that includes deliberate practice, feedback and reflection and (4) reassessment and certification of competence.

In physiotherapy in the Australian context, students typically take a number of placements across a range of practice areas. There is usually a single clinician for each placement who directs and monitors student activity, provides feedback, conducts longitudinal assessment and fills out requisite paper work for the university. Although one clinician takes responsibility as primary supervisor, many clinical placements are typified by multiple clinicians who observe learner performance, and provide informal feedback to both the learner and the primary supervisor. The clinical supervisor may make decisions as to how much autonomy the learners will have (Clouder 2009) as well as frame learning opportunities for the physiotherapy student (Trede and Smith 2012), indicating both the complexity and the significance of this relationship.

This study, although focusing on physiotherapy education, has implications for broader understanding of practice placements and the relationship between supervisors and underperforming students. The research questions were:

- What are physiotherapy clinical educators' experiences when working with underperforming students in the clinical setting?
- What strategies do they use to support underperforming students?

Methods

Three 90-minute focus groups were held with physiotherapy clinical educators, who were associated with a university department running an entry-level physiotherapy programme ($N=26$). Researchers (E.M. and J.K.) conducting the focus groups were qualified physiotherapists from the department and were, therefore, 'insider' researchers (Morse 2010). Participants were recruited via email to all clinical educators affiliated with the department. This is not an exclusive affiliation; educators may provide or have provided clinical education for other physiotherapy programmes. These clinical educators, like most within Australia, primarily deliver services. While training in educational supervision was offered through the department, this was not compulsory. Participant had access to resources which supported the use of a national assessment instrument, to assess students' progression, but these materials did not include explicit information on underperforming students. However, the department supported opportunities for all clinical educators to liaise with each other and with academic staff from the university with clinical education expertise.

The opening focus group questions were broad, designed to invite clinical educators to describe their experiences of working with learners in the clinical setting, and were progressively focused to elicit clinical educators' approaches to working with underperformers. The 'insider' status and existing rapport with the clinical educators afforded an openness and familiarity with the context during the focus groups. Participants were experienced clinical educators from three teaching hospital services and delivered musculoskeletal, neurological, cardiopulmonary and geriatric physiotherapy services. Focus groups were each 60–90 minutes, were audio-recorded and transcribed, and are denoted as Focus Group 1 (FG1), Focus Group 2 (FG2) and Focus Group 3 (FG3).

Qualitative analysis was based on grounded theory techniques (Kennedy and Lingard 2006; Strauss and Corbin 2008). Three researchers (E.M., J.K. and M.B.) independently 'open' coded the data for themes and subthemes. An extended analysis framework was developed based on these triangulated codes by a single researcher (M.B.), cross-checked against transcripts, circulated to all researchers, discussed and adjusted. As an 'outsider' to the clinical education context, M.B. provided alternative perspectives to the analysis. As Poland and Pederson (1998) note, things that are unsaid are equally important and the 'silences' within the text were included in our analysis.

A fourth researcher (R.A.), also a qualified physiotherapist but independent to the teaching programme and the research design, independently read the analysis and compared themes against transcripts. Axial links between these themes and

subthemes were explored. The associated theory and model were simultaneously negotiated among the researchers. An audit trail was maintained.

Ethics approval was granted by the Monash University Human Research Ethics Committee (CF09/0282 – 2009000088).

Results

The results are presented in two parts: (1) the experiences of working with underperforming students; and (2) the strategies that clinical educators used when supervising underperforming students. The participants' experiences of being educators in a clinical environment emerged as an important detail for understanding how they chose to deal with underperforming students. Their strategies for working with underperformers were mostly approaches or actions that they took when working as educators in general, and tended to involve more observation, more performance-based feedback, and on occasion, more supervision by an external source than typically provided. Box 1 contains an overview of themes and subthemes related to educator experiences. Box 2 contains an overview of themes and subthemes related to educator strategies. In the text, bold represents themes, bold italics are used for subthemes and italics represent the lowest level.

Experiences

Clinical educators described their **multifaceted role** as physiotherapist/clinician, supervisor, educator, mentor and assessor – with *competing responsibilities* to patient care, individual students, junior colleagues, the student cohort as a whole, the profession and the university. Fulfilling these responsibilities was described as a *difficult balancing act* and one that required *multiple, dynamic and continuous judgements*, particularly in monitoring that student practices were safe:

...I have a responsibility primarily to my patient, and my patient's safety, and my second priority is my responsibility to the profession. And if I feel that I can't pass this

Box 1. Clinical educators' experiences when working with underperforming learners.

<p>Multifaceted role</p> <ul style="list-style-type: none"> Competing responsibilities Difficult balancing act Multiple dynamic and continuous judgements <p>Demanding environment</p> <ul style="list-style-type: none"> Isolated as educators Profession entry gatekeepers Heavy educational and clinical workloads Responsibility for facilitating move from classroom to clinic <p>Stresses of working with underperforming students</p> <ul style="list-style-type: none"> Unacceptable learner behaviours Students' mental health issues Time and energy demands Taking personal responsibility for student progression
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Box 2. Clinical educators' strategies when working with underperforming learners.

'Diagnosis'
Formal tools
Documentation
Intuitive responses
Second opinions
Previous placement history
'More more more'
More of the same
Managing autonomy levels
Revised clear expectations
More supervision and feedback
More of themselves
Limited alternative strategies
Deficit of focused strategies
Shifting responsibility to the student
Patient-centred focus

student no matter how much effort we all put in, then the person is...not safe to be treating my mother or my grandmother. FG1

Some found the potential for students to provide less than effective patient care particularly challenging:

... Sometimes it is a real struggle to watch your patient being treated or assessed sub-optimally. FG2

The clinical education context was viewed as a **demanding environment**. In some clinical settings, education was not valued, or adequately supported. Some educators were *isolated* and had to make high stakes judgements about student capability without consultation with colleagues. In these instances, they often regarded themselves as the sole *gatekeepers* for students' progression into the profession:

... those last few days [in placement] when you are going, 'Oh, is this okay or not?' That is stressful because the stakes are really high for the student and to get that wrong would not be good. And you can't get more information at that point. You just have to make those calls [about failing a student] on your own. FG2

Some were juggling *heavy educational and clinical workloads*:

I have just seen people in and out of that position [clinical educator] for the last few years... because they couldn't cope... it was a busy case load, and you have students all year and half the time [the students] are saying they don't really like cardio. So you know it is a somewhat thankless task. FG2

Many commented about the difficult task of facilitating transference of students' skills from *the classroom to the clinic*:

A lot of the students who are sort of very good academically, are often very challenged, they find it confronting when they're unable to get the result they expect from a patient. FG1

In addition to this already challenging work environment, clinical educators described the considerable **stresses of working with underperforming students**. They reported *unacceptable learner behaviours* and recounted learner *mental health issues*, without the support or skills to manage them. Many clinical educators invested additional (and scarce) *time and energy* into these students, with a good number *taking personal responsibility* for ensuring that they 'get students over the line':

On a personal level it's exhausting because I want the student to get over the line. FG3

Strategies

The first strategy that clinical educators used when faced with an underperforming student is covered by the theme of '**diagnosis**'. This was a process of identifying discrepancy between the expected performance standard and the demonstrated performance, and then trying to establish the reason for underperformance. When describing how to identify and 'workout' these 'difficult students', educators often chose to draw on language typically applied to patient care such as 'diagnose' and 'clinically reason':

My biggest thing that comes to mind about doing something for underperforming students is to try and really clinically reason...is contributing to their under-performance. FG3

Some used *formal tools* set out by the university to support this problem solving process:

The time when I go to those performance indicators [in the formal assessment tool] is when I've got a student that's not performing well...it helps me isolate [the problem]. FG3

Others relied on *documentation* to identify unsatisfactory performance and support learning:

My journal, my documentation helps me reflect on what it is that the student's not doing.... FG3

Some described an *intuitive response* for identifying underperformance, linked to perceived student effort or enthusiasm:

You can...pick it from the first week, how your clinic's [clinical placement] going to go based on what they're giving of themselves. FG1

Others sought a *second opinion* to validate the identification of underperformance:

I guess we commonly do it with failing students – just to get someone else to just have a look. FG2

Clinical educators also articulated that the difficulties in identifying underperformers were exacerbated by a fragmented approach to clinical placements, typified by a lack of transparency of the *learners' previous placement history*, known as 'feedforward'. In the context of this particular study, the physiotherapy programme had a policy that information about the student is not communicated between placements, to minimise potential bias against the student. Students are encouraged to complete a form describing their learning needs at the start of each clinical placement, to open discussion about previous placement experiences and to promote reflective skills. Educators reported that this lack of educator 'feedforward' limited the capacity to identify and support underperformers early in the placement. They reported a belief that some students place responsibility for current underperformance on failings of previous placements or educators. Likewise the 'learning needs' form was sometimes used to argue for failure of previous educators rather than as a method for developing a framework for learning:

I've had students that have used that learning needs form on day one as a bit of a way to flag the feedback about their under performance in their previous clinic that they didn't like and that they didn't think was justified. FG3

Once the students were identified as poor performers, clinical educators tended to use strategies, which we have grouped under the theme '**more more more**'. That is, the clinical educators used *more of the same* general educational strategies that they used with all students, or provided *more supervision and more feedback* or simply put *more of themselves* into helping the student in difficulty.

It is worth noting that the '*more of the same*' strategies described by clinical educators were perceived to be effective educational tools, irrespective of student performance for many students. Two commonly reported approaches were *providing clear expectations* and *managing learners' autonomy levels*.

Clinical educators spoke about providing *clear expectations* of the clinical placement as a requirement for all learners, regardless of their perceived competence but these expectations were revisited with underperforming learners. Clinical educators also described judgements they made about learner ability, and how they matched this ability to task complexity and, importantly to level of supervision; they were essentially *managing learner autonomy levels*:

You've got to gauge very early on how much risk [you can take] with a certain student . . . some really good students that you can really give them independence . . . but some students really struggle and [it's just about] basic safety. FG3

These judgements regulated level of supervision and monitoring of weaker students and led educators to providing *more supervision and more feedback*, in an attempt to cultivate insight into their underperformance and ensure patient safety. Sometimes this led to situations where 'a particular[ly] difficult student will need that constant supervision and prompting' FG2.

Some clinical educators described 'pulling in' other clinical educators to provide extra supervision and feedback, often in an attempt to make reluctant students understand their deficits through reinforcement from multiple perspectives. As one participant described:

They'll throw at you 'well, that's just your opinion'. And [then] you get a second supervisor. FG1

Another strategy for some was to provide 'blunt' feedback, which while confronting in the short term was seen as a way to help the learners' immediate performance and help develop learner insight:

I find sometimes you just have to be blunt. Unfortunately, that gets tears flowing, but sometimes you can just see that they are not going to get through if they keep going on something. So you just have to let them know. Because at least that then gives them some insight and hopefully by the end of the placement, they can come to you and say this is what I need to work on. FG2

The most common, but not universal, response to underperforming students was for clinical educators to put *more of themselves* into the supervision and its associated tasks:

I gave her lots and lots of feedback, but perhaps... I felt like perhaps the reason she didn't have insight into the fact that she was failing was because I didn't nail it often enough that she wasn't doing enough. FG2

The 'more more more' theme is also accompanied by **limited alternative strategies**. This absence of alternative strategies was articulated by one participant:

Clinical educator: ... you point out things [to the underperformers] that you see going wrong but whether they're receptive to that or not is another matter.

Facilitator: And if they're not [receptive], is there a Plan B?

Clinical educator: Ah, I don't have any other plans aside from that.

We noted a *deficit of focussed strategies*. Clinical educators barely made reference to matching of learner skills to set tasks which were designed to improve particular skills, or reducing the size of learners' patient lists to allow for more planning and more time per consultation, or more time for learner reflection following a consultation.

There were instances where clinical educators found ways of what might be called 'breaking the cycle'. A few clinical educators advocated the merits of *shifting responsibility to the student*. This approach was seen as forcing the underperforming student to take ownership of their performance as well as reducing clinical educator stress. The approach outlined by these clinical educators was atypical of our participant sample:

the big thing that has happened and [had] most impact on my stress levels... has been really shifting my thinking to put the responsibility back onto the student to pass their own clinic; it's not my responsibility to pull them over the line, it's my responsibility to give them clear objective feedback that is based on their behaviour and their performance, and help them identify strategies on how they can improve... FG3

There was a sense that other clinical educators had tried to shift responsibility to students but with underperformers, who were unprepared or unable to discuss their deficiencies, this was more difficult. One clinical educator articulated:

[the one's that say] I'm not going to let you know anything about me because that might expose some weakness... they're the ones that are really unsuccessful.

Other clinical educators described introducing a *patient-centred focus* through describing the consequences of poor clinical management. This refocusing strategy served two purposes: to motivate student behaviour change through highlighting the importance of the student's actions on patient outcomes and also as a way to diminish focus on the individual:

I had a student in my office for a follow-up, and what has been fascinating to me is that they've never considered the consequences of their unsafe practice. They've never actually had a person fall, and you go 'what could that lead to and what is the implication if they break a hip? they've thought 'oh they might fall, o.k. I might fail', but they hadn't actually thought what is the consequence to this person.

Figure 1 shows our theorised cyclical interrelationships between the difficulties of being a clinical educator, the strategies for managing underperforming students and associated stresses.

Discussion

The first section of the results – 'experiences' – reinforces the view that clinical education by its nature is complex and requires 'juggling' roles such as manager, assessor, teacher and health care practitioner (Lefevre 2005; Rose and Best 2005). Our analysis indicates that the relationship between the clinical educator and the underperforming student extends existing complexities. This echoes 'failure to fail' research, which describes the difficulties in managing clinical roles and simultaneously supervising and assessing novice practitioners (Cleland et al. 2008; Monrouxe et al. 2011; Wellard, Williams, and Bethune 2000; Young 2004). Adding to this complexity is the belief by some physiotherapy clinical educators that it is a failing on their part if a student fails their clinical placement. This belief and accompanying emotional load may help in part to explain why educators may be

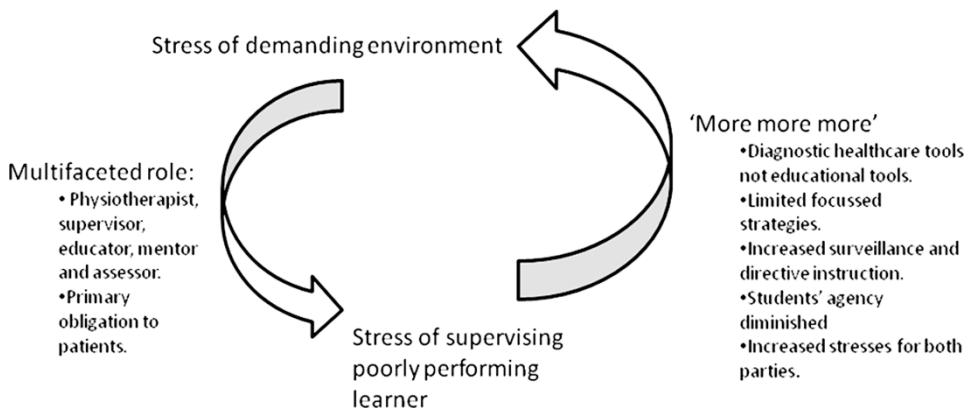


Figure 1. Cyclical nature of clinical educators' experiences of working with underperforming learners.

reluctant to fail students and to explain their distancing of personal responsibility for failing to fail underperformance as an act of 'saving face' (Monrouxe et al. 2011).

The second section of the analysis – 'strategies' – illustrates how these role tensions transfer into clinical educators' methods for working with underperforming learners. The theme 'diagnosis' refers to the term used by clinical educators to describe labels applied to causes of underperformance. It may be important to challenge the notion and utility of a diagnostic approach. The use of the term *diagnosis* as drawn from health care discourse, which is used repeatedly when referring to underperformers (Hauer et al. 2009; Vaughn, Baker, and Dewitt 1998), implies that once a diagnosis is made by the clinical educator, they can then intervene to fix the problem. This approach seems to ignore the role of the learner in the educative approach and places the responsibility for the students' passing/failing firmly on the clinical educator in terms of identifying potential causes and strategies for curing the condition. Positioning of the clinical educator as the expert and the student as the passive receiver of actions imposed upon them may be detrimental to development of students' self-efficacy and agency (Molloy 2009). While there may be cases when it is useful to identify the cause(s) of difficulties that affect student performance, this can be done in partnership with the student, with focus upon improvement rather than upon causation.

Overwhelmingly, the response to a failing student was to provide 'more more' rather than to engage in structured and directed support. This reinforces the notion of the clinical educator as the driver of learning. If participants are failing to progress, then by doing 'more' the clinical educator will 'get them over the line'. The identification of underperforming students resulted in clinical educators 'watching everything, [and] writing down every little thing they do that's unsafe'. This hypervigilance has been reported by students in the past (Molloy 2009) and is often described by clinical educators as necessary to ensure patient safety. This contrasts with Clouder's (2009) study of physiotherapy students which describes the positive impact of clinical educators entrusting learners with patient care responsibilities as providing 'a personal reference point upon which to build capability'. We argue that the educational impact of constant monitoring is likely to be counterproductive in terms of the students' self-concept, anxiety levels and ability to self-regulate their learning.

The participants did not report developments such as 'shared action plans' (Luhanga, Yonge, and Myrick 2008c) or 'an individualised learning plan' (Hauer et al. 2009) tailored to the student in difficulty. Such tools mandate an early discussion of placement goals and expectations, and promote discussion of the student's knowledge/skill deficits. They serve as a reference point for subsequent performance management discussions and, therefore, may assist both parties in the learning relationship to literally and metaphorically 'work off the same page'. Plans might include explicit discussion of student autonomy and circumstances where responsibility can be safely handed to the learner. The advantage is that this 'de-personalises' what can be a challenging issue (McGregor 2007). As with the strategy described by many clinical educators – of 'personalising the patient story' – an emphasis on outcomes or impact of behaviours serves to reorientate discussion from a focus on the learner's deficits, to explicating the reference standards of practice, with optimising patient well-being framed as the central goal.

The clinical educators reported underperforming learners discounting previous feedback. This learner tendency for ‘deflection’ has been noted in previous studies when there is a discrepancy between learners’ internal perceptions (self-evaluation) and the external teacher’s perceptions as represented by feedback (Molloy and Boud, forthcoming). Carless et al.’s (2011) research suggests that the emergence of such a discrepancy triggers the receiver/learner to reinterpret the external feedback to make it conform with their own hope, intention or interpretation of their performance. The interplay of fear, confidence and reasoning processes has been found to impact on responsiveness to feedback (Eva et al. 2012). Handling this type of ‘deflection’ requires an understanding that no matter how frequent or loud or triangulated feedback is, the message is likely to be rejected by the learner.

This discussion highlights that working effectively with the underperforming learner is not only contingent on refining the microskills of clinical educators within a teaching episode, but also hinges on wider system (or programme) design issues in recognition of the strains on the clinical educators in a cycle of increasing stress. Programme changes could build upon current models, which already promote reflective practice. New developments may include learning contracts and nested assessment activities, which emphasise student responsibility for learning as well as structured support for educators in providing cyclical practice and feedback opportunities. Other systems changes may include working with clinical educators to identify better ways of managing issues of stress and overload, or transition programmes (Molloy and Keating 2011) to prepare students for the expectations and demands of clinical education, emphasising the importance of feedback in learning and developing skills in giving and receiving feedback (Molloy 2010).

The role of the university, once a student is identified as underperforming, requires further exploration. It is worth considering how further experiential learning for an individual student is facilitated following a ‘failed’ clinical placement and what supports (including dealing with residual guilt) are given to educators who have had to deal with underperforming learners. Clinical educators highlighted another issue for further investigation: ‘closing the loop’, where information about the student is ‘feedforward’ by staff across placements versus relying on the student’s self-report as the sole feedforward mechanism. Recommendations in the literature are for remediation programmes that respect or conceal students’ identity as repeaters (Winston, Van Der Vleuten, and Scherpbier 2010) and that preserve self-concept (Eva et al. 2012). This ‘clean slate’ approach positions the student with agency for crafting a new learning experience under different conditions, rather than being tagged a ‘problem student’ that may influence educator perceptions and assessment. However, opinions about whether sharing information about struggling students is appropriate are divided [e.g. see Frelsen et al. (2009) and associated letters and commentary].

In the context of the underperforming student who is typically poor at self-assessment (Kruger and Dunning 1999) and potentially unresponsive to external feedback, what is the clinical educator to do? Consulting the literature seems to provide few evidence-based strategies for remediation. This is a complex system where clinical work and education intersect and we argue for wider system or programme redesign rather than a focus on microskill development.

A limitation of this study is that it is confined to clinical educators affiliated with one Australian physiotherapy programme although clinical educators spoke

generally about their experiences supervising students across institutions. We also note that focus groups were conducted by two researchers who are university-based which arguably may have limited blame shifting to the university. This potential limitation was balanced against the perceived comfort and existing rapport between the researchers and participants in the design of the study. The design of the study precluded an iterative data gathering process to illuminate some of the ‘silences’. For example, the university role in the general day-to-day management of underperforming learners in the clinical environment was little discussed, but participants were not specifically asked about this during the focus groups. Student perspectives might also provide a greater insight into some of the issues and potential solutions. Future research could take a video-reflexive approach (Iedema 2011) to deeply understand the relationship between the educator, the underperforming learner and the environment/system leading to the co-construction of strategies and remediation activities within the clinical environment setting by educators, students and researchers.

Conclusion

This is the first study, to our knowledge, to describe clinical educators’ experiences and strategies of working with underperforming physiotherapy students. A key finding was that supervisors felt responsible for student success in clinical education. When students were underperforming, educators described a sense of failure and provided more, rather than different, support for student learning. They rarely described strategies that were tailored to address the specific learning needs of individual students. We propose a cycle of rising stress between the pressure of managing underperforming learners and the clinical educators’ conflicting roles and responsibilities. Rather than trying to do more within an already stretched system, we argue that it is necessary to rethink the pedagogical approach to this complex issue. Educators may benefit from wider system and programme developments, such as learning contracts and nested assessment activities, to focus on providing effective learning opportunities within a practice environment.

References

- Carless, D., D. Salter, M. Yang, and J. Lam. 2011. “Developing Sustainable Feedback Practices.” *Studies in Higher Education* 36: 395–407.
- Cleland, J., R. Arnold, and A. Chesser. 2005. “Failing Finals is Often a Surprise for the Student but not the Teacher: Identifying Difficulties and Supporting Students with Academic Difficulties.” *Medical Teacher* 27: 504–508.
- Cleland, J. A., L. V. Knight, C. E. Rees, S. Tracey, and C. M. Bond. 2008. “Is it me or is it them? Factors that Influence the Passing of Underperforming Students.” *Medical Education* 42: 800–809.
- Clouder, L. 2009. “‘Being Responsible’: Students’ Perspectives on Trust, Risk and Work-Based Learning.” *Teaching in Higher Education* 14: 289–301.
- Dudek, N. L., M. B. Marks, and G. Regehr. 2005. “Failure to Fail: The Perspectives of Clinical Supervisors.” *Academic Medicine* 80: S84–S87.
- Eva, K., H. Armson, E. Holmboe, J. Lockyer, E. Loney, K. Mann, and J. Sargeant. 2012. “Factors Influencing Responsiveness to Feedback: On the Interplay Between Fear, Confidence, and Reasoning Processes.” *Advances in Health Sciences Education* 17: 15–26.

- Frellsen, S. L., E. A. Baker, K. K. Papp, and S. J. Durning. 2009. "More about Struggling Students." *Academic Medicine* 84: 151–152. doi:10.1097/ACM.0b013e3181939937.
- Hauer, K. E., A. Ciccone, T. R. Henzel, P. Katsuftrakis, S. H. Miller, W. A. Norcross, M. A. Papadakis, and D. M. Irby. 2009. "Remediation of the Deficiencies of Physicians Across the Continuum from Medical School to Practice: A Thematic Review of the Literature." *Academic Medicine* 84: 1822–1832. doi:10.097/ACM.0b013e3181bf70.
- Hayes, K. W., G. Huber, J. Rogers, and B. Sanders. 1999. "Behaviors that Cause Clinical Instructors to Question the Clinical Competence of Physical Therapist Students." *Physical Therapy* 79: 653–667.
- Hrobsky, P. E., and A. L. Kersbergen. 2002. "Preceptor's Perceptions of Clinical Performance Failure." *Journal of Nursing Education* 41: 550–553.
- Iedema, R. 2011. "Creating Safety by Strengthening Clinicians' Capacity for Reflexivity." *BMJ Quality & Safety* 20: i83–i86.
- Kennedy, T. J. T., and L. A. Lingard. 2006. "Making Sense of Grounded Theory in Medical Education." *Medical Education* 40: 101–108.
- Kilminster, S. M., and B. C. Jolly. 2000. "Effective Supervision in Clinical Practice Settings: A Literature Review." *Medical Education* 34: 827–840.
- Kruger, J., and D. Dunning. 1999. "Unskilled and Unaware of it: How Difficulties in Recognising One's Own Incompetence Lead to Inflated Self-Assessments." *Journal of Personality and Social Psychology* 77: 1121–1134.
- Lefevre, M. 2005. "Facilitating Practice Learning and Assessment: The Influence of Relationship." *Social Work Education* 24: 565–583.
- Luhanga, F., O. Yonge, and F. Myrick. 2008a. "'Failure to Assign Failing Grades': Issues with Grading the Unsafe Student." *International Journal of Nursing Education Scholarship* 5: Article8.
- Luhanga, F., O. Yonge, and F. Myrick. 2008b. "Precepting an Unsafe Student: The Role of the Faculty." *Nurse Education Today* 28: 227–231.
- Luhanga, F., O. Yonge, and F. Myrick. 2008c. "Strategies for Precepting the Unsafe Student." *Journal for Nurses in Staff Development* 24: 220–221. doi:10.1097/01.NND.0000320683.26813.93.
- McGregor, A. 2007. "Academic Success, Clinical Failure: Struggling Practices of a Failing Student." *Journal of Nursing Education* 46: 504–511.
- Miller, G. E. 1990. "The Assessment of Clinical Skills/Competence/Performance." *Academic medicine: journal of the Association of American Medical Colleges* 65: S63–S67.
- Molloy, E. K. 2009. "Time to Pause: Feedback in Clinical Education." In *Clinical Education in the Health Professions*, edited by C. Delaney and E. K. Molloy, 128–146. Sydney: Elsevier.
- Molloy, E. K. 2010. "The Feedforward Mechanism: A Way Forward in Clinical Learning?" *Medical Education* 44: 1157–1159.
- Molloy, E. K., and D. Boud. (2012). "Performance Feedback." In *Handbook of Research on Educational Communications and Technology*, 4th ed. edited by M. Spector. Springer Academic.
- Molloy, E. K., and J. Keating. 2011. "Targeted Preparation for Clinical Practice." In *Promoting Professional Learning: Integrating Experiences in University and Practice Settings*, edited by S. Billet and A. Henderson, 147–172. Dordrecht: Springer.
- Monrouxe, L., C. Rees, N. Lewis, and J. Cleland. 2011. "Medical Educators' Social Acts of Explaining Passing Underperformance in Students: A Qualitative Study." *Advances in Health Sciences Education* 16: 239–252.
- Morse, J. M. 2010. "How Different is Qualitative Health Research from Qualitative Research? Do we have a Subdiscipline?" *Qualitative Health Research* 20: 1459–1464.
- Poland, B., and A. Pederson. 1998. "Reading Between the Lines: Interpreting Silences in Qualitative Research." *Qualitative Inquiry* 4: 293–312.
- Rose, M., and D. Best, eds. 2005. *Transforming Practice Through Clinical Education, Professional Supervision and Mentoring*. Edinburgh: Elsevier.
- Strauss, A. L., and J. M. Corbin. 2008. *Basics of Qualitative Research Techniques and Procedures for Developing Grounded Theory*. 3rd ed. Los Angeles: Sage.
- Trede, F., and M. Smith. 2012. "Teaching Reflective Practice in Practice Settings: Students' Perceptions of their Clinical Educators." *Teaching in Higher Education* 17: 615–627.

- Vaughn, L. M., R. C. Baker, and T. G. Dewitt. 1998. "The Problem Learner." *Teaching and Learning in Medicine* 10: 217–222.
- Wellard, S. J., A. Williams, and E. Bethune. 2000. "Staffing of Undergraduate Clinical Learning Programs in Australia." *Nurse Education Today* 20: 548–554.
- Winston, K. A., C. P. M. Van Der Vleuten, and A. J. J. A. Scherpbier. 2010. "At-Risk Medical Students: Implications of Students' Voice for the Theory and Practice of Remediation." *Medical Education* 44: 1038–1047.
- Young, M. 2004. "Conceptualizing Vocational Knowledge: Some Theoretical Considerations." In *Workplace Learning in Context*, edited by A. Fuller, A. Munro, and H. Rainbird, 185–200. London: Routledge.

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