Dealing with a Difficult Learning Situation: ***Prevention***

The vast majority of learning encounters proceed smoothly with significant benefit for the learner and often a sense of reward and accomplishment for the clinical instructor. On occasion, however, there is a learning situation where things do not run smoothly. The old adage "an ounce of prevention is worth a pound of cure" is as true in clinical teaching as it is in clinical medicine. It is generally much more efficient (and pleasant) to prevent a problem than to manage the negative impact once it has occurred. Approaches to prevention in teaching can be divided into categories of primary, secondary and tertiary prevention. In healthcare, as in education, primary prevention has the goal of avoiding the problem before it occurs. Secondary prevention has the goal of detecting an issue early and acting to minimize the effects of the problem. Tertiary prevention is the management of existing problems to limit the negative impact those problems may create. Each level of prevention has its own characteristics and strengths.

Primary Prevention:

As in healthcare, the prevention of problems before they occur is ideal. Fortunately there are strategies that can prevent difficult teacher/learner interactions. Those include being informed and clear about the **expectations** for the learning experience, taking the time to **orient the student** to those expectations, and setting clear expectations and goals and **role modeling t**hat behavior.

Consider the following when preparing for a student placement and throughout the student placement:

- What are the school/Program expectations and goals for the experience?
- What are the student's expectations for the experience? Ask the student how he expects the first week to go, how his previous rotations have progressed, how he feels he learns best, what he is most nervous about, and what his particular challenges are.
- What are your expectations for student performance/behavior? Have you expressed those to the student? Are you actively working to role model those behaviors (and are other staff in the department role modeling those)?

All too often problems emerge because the student and the CI were not on the "same page" with expectations. The CI may assume that the student "*should know*" what is expected but that is often an **unfair assumption**. Consider the following scenarios that might have been avoiding by practicing primary prevention:

Student expected to be able to jump in and start treating patients by the end of the first week; CI thought that since this was a first rotation the student should mostly observe. Neither expressed that expectation, though, so both are frustrated.

Student arrives at clinic by 8:00 but is negatively perceived because she is not there early. No one indicated to the student, however, that she is expected to arrive by 7:50. Other PT department staff routinely arrive at 8:00 (or later).

Secondary Prevention:

If primary prevention has not succeeded then early detection of problems is essential. Be sure you're using these strategies to manage issues:

1. Be **alert for clues** (red flags/yellow flags) that there may be a problem. Don't use a "wait and see" approach which may result in an entire clinical experience going by without an opportunity to intervene and correct the issue.
2. Address problems as they arrive **explicitly** (don't just "hint" to the student that there is an issue). Putting expectations and goals for improvement in writing is the best approach.
3. Be sure that you are remaining calm and professional and that you are addressing the specific **observable behavior** and not critiquing the student personally (which will automatically elicit a defensive response).

Consider the following scenarios that might have been avoiding by practicing good secondary prevention:

Student likes to learn by asking questions throughout the treatment session. CI feels she has given "body language" that she prefers to answer questions at the end of the day. By the time the CI does discuss it with the student there is a tone of frustration in her voice.

CI notices her student on his cell phone and chatting with department staff when he should be attending to the patient in the PT gym. The CI decides not to address it just yet (maybe it won't happen again). The behavior continues, and by this point other staff have noticed it and one comments to the student that he is "very unprofessional".

Tertiary Prevention:

Sometimes despite your best efforts as a CI, problems continue. Avoid the temptation to "just stick it out". This is the time (if you have not already done so) to DEFINITELY enlist the help of the school (ACCE/DCE). This individual can give you insights into the student's behavior, suggestions for documentation and feedback, can discuss expectations with the student, and can certainly (if needed) remove the student from your clinical setting.

At every level of prevention, using the **SOAP approach** can be useful in documenting, preventing and managing identified problems.

S: Subjective—Be sure that you are getting all of the information. Are other staff in the department having any issues with the student? (Example: student may be nervous in interaction with CI affecting his performance, but does well in less stressful situations). What is the student's perspective? (Example: Student may be aware of the difficulty and may be actively working to improve… or may have been completely unaware that a particular behavior was perceived as a problem at all)

O: Objective—It is important to describe/list for the student the specific behaviors that are undesirable. (Examples: More than 20 mins late Mon and Tues this week. Taking 30+ mins to complete 2 patient notes. Unable to recall ACL precautions even after review. Observed speaking "over" patients on 3 occasions when listening would have been the appropriate/preferred action.)

A: Assessment—Diagnosing the cause of the behavior is an important step. Is it a cognitive issue (student needs to study and increase knowledge base)? Affective issue? (student is nervous/intimidated, student is not enjoying the setting/not motivated, student values or expectations are in conflict with CI or site)

P: Plan—Should be in writing and may include gathering more data, recommendations and goals for change, getting feedback and assistance from school, and opportunities for practice and improvement in the identified area of weakness.

Using these tools can help make a difficult situation manageable and will help prepare the student for success which is the ultimately the goal of clinical education!

Article written by Kim Cox, based in part on information from "How to Teach and Learn in Medical School.", Quirk, M. E.