

MODULE 1

THE EFFECTIVE

PRECEPTOR

THE EFFECTIVE PRECEPTOR

INTRODUCTION

As a health care professional you strive to maintain and improve your knowledge and skills in order to provide the highest quality of care possible. For many of you, this passion for excellence spills into other areas of your lives and professional work, and the evidence is seen in the high quality of teaching provided by preceptors.

This module will review some of the literature on the characteristics of effective clinical teachers and preceptors.

Upon completion of this module you should be able to

1. List the characteristics of the effective clinician.
2. Apply the qualities that characterize effective clinical care to the characteristics of the effective preceptor.
3. List and discuss characteristics of the effective preceptor as indicated by research.
4. Explain the concept of becoming a connoisseur of excellent teaching.

Reading this module alone will probably not make you an effective preceptor. However, it may show where your excellence already lies and encourage your efforts towards continuous improvement.

COMMUNICATION AND THE EFFECTIVE PRECEPTOR (Table 1)

Communication for the effective clinician is clearly a complex exchange of information between the parties involved. The same is true for the effective preceptor.

There is more involved than the demonstration or passive transfer of clinical information. The preceptor must not only share his or her own knowledge but should be open to views in conflict with his or her own (Stritter & Baker, 1982). The effective teacher/preceptor is also personable and approachable (Irby et al., 1991). Listening to the learner and being open to and respecting their ideas and opinions strengthen the preceptor/learner relationship in the same way the openness and respect with patients is vital in the nurse/patient relationship.

Connecting information to broader concepts is important in patient care and teaching. For example, in patient care, the anxious patient must generalize the effect of his or her stress in order to see the connection to insomnia, headaches and indigestion. Similarly, the learner needs assistance in taking the information from a specific case and generalizing it to other clinical situations {Irby 1994 #1440}.

Clear communication of goals is vital to effective precepting (Skeff, 1988). Too often preceptors do not define the specific observable behaviors that are desired. When clear expectations are set and communicated, the learner is better able to focus his or her energies and efforts and assist you in measuring your own effectiveness.

Table 1

COMMUNICATION AND THE EFFECTIVE PRECEPTOR

The Effective Preceptor:

- 1) Possesses and demonstrates broad knowledge**
- 2) Explains the basis for actions and decisions**
- 3) Answers learner questions clearly and precisely**
- 4) Is open to conflicting ideas and opinions**
- 5) Connects information to broader concepts**
- 6) Communicates clear objectives and expectations**
- 7) Captures learner's attention**
- 8) Makes learning fun**

The environment in which teaching takes place has a major effect on the transfer of information. For example, the clinician's body language and tone of voice has a significant effect on communication with the patient. Likewise, learners remember more when a preceptor can capture their attention and make learning fun (Irby, 1994). This can be accomplished by using humor, dramatic case examples, suspense and enthusiasm.

In summary, the effective preceptor communicates his or her clinical knowledge clearly to the learner while remaining open and respectful. Specific concepts are expanded to general principles. Careful listening indicates respect for the learner. Objectives and expectations are defined and clearly communicated, and a pleasant and stimulating learning environment is fostered using humor and enthusiasm.

CAREFUL ANALYSIS OF THE LEARNER (Table 2)

The most skillful clinical interview and physical examination is useless if the clinician is not able to analyze the information and use it to assist the patient in his or her problem. The effective preceptor analyzes the data obtained from his or her interaction with the learner and uses this information to benefit the learner through assessment, feedback and evaluation.

In order to accurately assess the learner's performance, the effective preceptor observes the performance directly as often as possible (Irby, 1995). Often a preceptor's observations tend to be secondhand – based on presentations or written information. It is important to directly observe the learner in order to give the necessary guidance.

Feedback is highly valued by learners (Goertzen, Stewart, & Weston, 1995) (Irby, 1995); (Skeff, 1988); (Stritter & Baker, 1982). It is the mechanism by which the effective preceptor promotes the positive behavior and skills and works to modify those areas where improvement is needed.

Table 2

CAREFUL ANALYSIS OF THE LEARNER

The Effective Preceptor:

- 1) Accurately assesses learner's knowledge, attitudes and skills
- 2) Uses direct observation of the learner
- 3) Provides effective feedback
- 4) Performs fair and thoughtful evaluations

Evaluation is a key function of the effective preceptor. Through clear goals and expectations, ongoing assessment of the learner, and continuing feedback to guide progress, the preceptor has integrated the evaluation process into the entire rotation. The final evaluation is the culmination of an ongoing process and is more relevant and valuable as a result. Schools value evaluations, but learners also value a fair and thoughtful evaluation {Goertzen, Stewart, et al. 1995 #1330}; (Irby, 1995) (Skeff, 1988) {Stritter & Baker 1982 #1420}).

SKILLS IN PRACTICE AND TEACHING (Table 3)

The demonstration of skill is important in clinical practice and in clinical teaching. Clinical precepting is more than telling someone what to do and how to do it: the effective preceptor not only “talks the talk” but also “walks the walk”. In the close quarters of the preceptor/learner relationship, true role modeling involves being consistent in what you say and do in your relations with patients, staff, and learners.

There is more to clinical teaching than just being an excellent clinician in the presence of others. Most of us can probably recall someone we have met or worked with who was an excellent clinician – an astute diagnostician, a compassionate provider of high quality care – who seemed unable to transmit this knowledge or skill to others. A colleague recalls:

“My preceptor was an expert nurse but she could not always communicate her knowledge. One morning during my orientation we make rounds on our patients together. After we finished, we were on our way back the Nurse's Station and she said she wanted to check back in on one of our patients who was going home that day. He was resting quietly with no complaints when we first make rounds. When we entered the room the second time, the patient was pale, diaphoretic and said he just did not feel well. He was having a MI and was deteriorating quickly.

We were able to intervene early and quickly, which most assuredly make a difference in his outcome. I later asked my preceptor why she had stopped back by the patient's room. She said she did not know exactly why but he just did not look right.”

Table 3

SKILL IN PRACTICE AND TEACHING

The Effective Preceptor:

- 1) Provides effective role modeling**
- 2) Demonstrates skillful interactions with patients**
- 3) Generates interest in the subject matter**
- 4) Presents information with organization and clarity**
- 5) Organizes and controls the learning experience**
- 6) Balances clinical and teaching responsibilities**
- 7) Give appropriate responsibility to the learner**

Just as a Nobel Prize winner may not be an excellent teacher of biochemistry or pharmacology, the top clinician is not necessarily the best teacher/preceptor. The best teachers/preceptors provide useful information in a creative way (Whitman, 1990).

The best preceptors must not only have knowledge and skill but must be able to share it in a way that is useful and interesting to the learner. Some would object to the assertion that the teacher/preceptor must be entertainer as well. I would only ask you to think back to a recent conference you attended. From which speaker did you gain more – the knowledgeable expert who presented his information in a flat and uninteresting manner, or the knowledgeable expert who captured your interest with a stimulating presentation?

Learners also value an organized approach to the precepted experience. Organization and clarity are just as important in the impromptu teaching in the unit as well in a formal lecture (Stritter & Baker, 1982). Actively directing the learning will help the learner meet small specific goals that build into greater accomplishments.

Just as the clinician needs to have control of the patient interview, learners value a preceptor's control of the teaching situation (Skeff, 1988). In the ambulatory setting there is intense pressure for efficient use of time. The clinician and the preceptor who plan and control the use of time effectively can better serve the needs of the patient and the learner. In managing the use of time, the effective preceptor sometimes makes difficult decisions regarding the conflicting needs of patients and learners. There must be a clear balancing of clinical and teaching responsibilities. An ability to do this well is valued by learners (Goertzen et al., 1995).

The effective preceptor recognizes that, when appropriate, he or she must relinquish some of the control in the clinical area to the learner. Shadowing can be a useful introduction to clinical care, but this technique alone grows old after several days of following the preceptor. Learners value appropriate increases in responsibility coupled with careful oversight and guidance (Irby, 1978) (Irby et al., 1991). With careful ongoing analysis, the effective preceptor can balance the educational needs of the learner with the needs of the patients.

MOTIVATING THE LEARNER (Table 4)

A clinician can make the correct diagnosis and prescribe the perfect therapeutic regimen, but if the patient does not accept the diagnosis and is not motivated to follow that regimen, the result will be disastrous. The situation is similar for the preceptor. Your communication, feedback and teaching skills may be top notch, but the results will be sabotaged if the learner is unmotivated.

Learners in health care professions usually enter their training with high levels of energy and motivation. Sometimes though, the rigors and challenges of the classroom teaching can take their toll, leaving learners depleted and questioning the relevance of what they have learned. The application of knowledge to solving problems and the generalization of the current experience to future patients can help revive flagging energy and waning motivation in early clinical training.

Adult learning involves internal motivation – learning because one wants to and not for some external reward such as a grade. Many of the learners we see have not made this transition to an adult learning style. Active involvement of the learner is a characteristic of the effective preceptor (Goertzen et al., 1995); (Irby, 1994) and is an important method of encouraging the adult style of learning and thereby increasing motivation. This clinical experience may be the first time that a learner has been able to select some of his or her own learning goals and to help direct the methods to best achieve them. This also can be an important step to life-long self-directed learning.

Table 4

MOTIVATING THE LEARNER
The Effective Preceptor:
1) Emphasizes problem solving
2) Translates specific cases into general principles
3) Promotes active involvement of the learner
4) Demonstrates enjoyment and enthusiasm for patient care and teaching
5) Develops a supportive relationship with the learner

A recurrent theme in reviewing the qualities of the effective preceptor is the value of enthusiasm (Irby, 1978). Demonstrating enjoyment of patient care and teaching is among the most important characteristics of the effective preceptor (Irby et al., 1991). With the current changes in health care this may be the characteristic that is most under siege. Pressure to take care of more patients, shrinking reimbursement, and increasing difficulty to fit teaching into a busy life are making it harder to be positive and enthusiastic. From time to time it is essential to stop, get beyond the pressures and demands of the minute, and look back to those qualities of patient care and teaching that are most important and rewarding to you. Enthusiasm is not something that can be faked; an honest discussion with the learner of the challenges you face and the values and ideals which keep you going can teach the learner a valuable lesson and boost your own motivation.

Finally, a supportive relationship with the preceptor motivates learners (Goertzen et al., 1995). The effective preceptor shows respect for the learner (Irby, 1995) and by doing so creates a safe environment for professional growth. Just as a growing bone is more fragile, the learner needs a safe environment characterized by trust and respect in which to build momentum, gain motivation, and achieve the maximum possible growth from the experience.

GROWING IN EFFECTIVENESS

Many healthcare professionals strive to constantly improve their skills in order to provide better care for their patients. This characteristic often extends to clinical teaching, where many of the best preceptors are constantly seeking to improve their skills. How does a preceptor move beyond effectiveness to excellence?

Whitman presents one strategy for improving one's teaching – by becoming a *connoisseur of teaching* (Whitman, 1990). Think for a moment about what it means to be a connoisseur. You do not become a connoisseur of wine just by drinking a lot of wine! Careful study of wine is needed. Connoisseurs carefully select and try new wines, choosing the good and learning to avoid the not so good. They seek out other knowledgeable wine tasters and exchange information. Their knowledge and skill increases with each new experience.

The preceptor seeking to be a teaching connoisseur studies teaching techniques. New strategies are carefully tested. Other preceptors are sought out and information and ideas are exchanged. Preceptor development activities are in many ways like wine tastings: often the exchanges between preceptors are the most valuable components of the events.

You have dedicated a significant amount of energy to becoming an effective clinician. By continued attention to communication skills, careful ongoing analysis, skillful practice, teaching and building motivation, your effectiveness as a preceptor will grow, as has your effectiveness as a clinician.

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MODULE 2

THE ART OF

FEEDBACK

WHY FEEDBACK IS IMPORTANT

INTRODUCTION

As a preceptor, you get to know your learners well. This close working relationship offers an excellent opportunity to share your assessment of the learners' strengths and weaknesses and help further develop their skills. In this module, you will explore effective ways of providing this feedback.

Upon completion of this module you should be able to

1. Define the characteristics of feedback.
2. Identify barriers that prevent preceptors from giving more feedback.
3. Outline an approach to giving effective feedback.
4. Describe how feedback can be incorporated into the clinical day.

Giving effective feedback is instrumental in helping learners learn. Learners who receive regular feedback about their performance perform significantly better (Scheidt, Lazoritz, et al., 1986; Stillman, Sabers, & Redfield, 1976, 1977), develop better judgement (Wigton, Kashinath, & Hoellerich, 1986), and learn faster (Hammond, 1971) than those who do not.

Furthermore, learners like feedback; they identify it as one of the most important qualities of a good preceptor, second only to clinical competence (Wolverton & Bosworth, 1985). Learners often report that they want more feedback from preceptors.

THE BENEFITS OF FEEDBACK

Feedback helps learners in a variety of ways. It helps learners evaluate their own performance. Preceptor feedback serves as a mirror in which learners can see what they do well and what they need to improve. It helps learners understand preceptors' expectations and whether they are meeting those expectations. Furthermore, a system of regular feedback encourages learners to try new skills: they can challenge themselves, experiment with new skills, and receive guidance that helps them develop mastery before being evaluated.

Feedback also makes preceptors' work easier. It provides an opportunity for the preceptor to show interest in learners' development. It facilitates communication. Feedback helps the preceptor to be proactive in identifying and addressing potential problem learning situations. Feedback makes the evaluation process easier, because the learner already knows the preceptor's assessment of his or her performance by the time they discuss the evaluation. At the same time that a preceptor's feedback helps learners improve, feedback from learners can help a preceptor improve their teaching skills.

CHARACTERISTICS OF FEEDBACK

Feedback is sometimes confused with evaluation, but the two differ in important ways (Table 1). Feedback is given as close to a given relevant event as possible, while evaluation is given at the end of a clinical experience. Feedback is often informal: brief sessions are fit in at appropriate times during a busy workday. Evaluation is usually performed in a more formal setting, where the learner and preceptor sit down for an "official review."

See Table 1.

Table 1

FEEDBACK COMPARED TO EVALUATION		
	Feedback	Evaluation
Timing	Timely	Schedule
Setting	Informal	Formal
Basis	Observation	Observation
Content	Objective	Objective
Scope	Specific Action	Global Performance
Purpose	Improvement	"Grading"

WHAT FEEDBACK AND EVALUATION HAVE IN COMMON

The basis for both feedback and evaluation should be objective data: specific behaviors that the preceptor has observed. However, feedback focuses on specific events or actions, while evaluation encompasses a broader level of performance and skills. The underlying purpose of *both* feedback and evaluation is improving learner performance; however, evaluation includes a summative evaluation that may impact a grade.

LEARNERS WANT MORE FEEDBACK

Learners often report that they do not get enough feedback from preceptors (Gil, Heins, & Jones, 1998; Irby, Gillmore, & Ramsey, 1987). Sometimes learners do not recognize the information preceptors share with them as feedback. It can help to explicitly label comments as such: "To give you some feedback...."

Most preceptors can give more feedback than they do. Preceptors sometimes think providing feedback is unnecessary, requires too much time, or is awkward to express. Each of these barriers can be overcome.

BARRIERS TO GIVING FEEDBACK

"They Know How They're Doing"

"Why say the obvious? The learners know how they are doing." Actually, they often do not. When people are first learning new skills, they do not have the experience or context for judging their own performance. What is obvious to you, an experienced clinician may still be unclear to learners.

"Is this an anomaly?"

"That episode was probably an anomaly." Sometimes you notice behavior that is potentially troubling, but you are not sure the learner consistently does it, and you do not want to make a mountain of a molehill. This may be particularly true at the start of the experience.

Check with colleagues and staff to see if they have observed similar behavior. It is okay to "act on the first itch" and raise the issue with the learner immediately – it is easier to prevent a potential problem than curb it once it has fully developed. You might say to the learner, "I don't know that this is something you normally do, but in this case I noticed that you..." or you can ask the learner for a self-assessment and see if this behavior is addressed.

"I don't have time."

"With this schedule, I don't have time to sit down and give a lot of feedback!" Feedback does not need to take a lot of time, and it is essential for helping learners improve. At the end of this module we will discuss specific strategies on integrating feedback into a busy day.

The Awkwardness

"This is awkward." "Learners get defensive." Many preceptors did not receive much feedback in their own training. Or the feedback they received did not adequately acknowledge their skills or include strategies to improve their weaknesses. These preceptors will naturally feel that learners get defensive in a situation during which feedback is provided.

The following model (Table 2) can help take the mystery and awkwardness out of giving learners feedback. And the more feedback you give, the easier it gets and the less "loaded" each individual feedback encounter feels to you and the learner.

I.M.P.R.O.V.E

HOW TO GIVE FEEDBACK

Feedback is an ongoing process that occurs throughout a clinical experience – and throughout a learner's education. Using the "IMPROVE" strategy can help preceptors set expectations with a learner, assess the learner's performance, and feed information back to the learner in a way that encourages improvement.

This strategy is summarized in Table 2.

Table 2

Giving Feedback To Help Learners IMPROVE
I dentify objectives with the learner
M ake a feedback-friendly environment
P rioritize what feedback to give
R espond to the learner's self-assessment
O bjective Observations should be made
V alidate what the learner has done well and/or suggest alternative strategies
E stablish a plan to implement changes (if needed) and have learner summarize feedback and plan

IDENTIFY OBJECTIVES WITH THE LEARNER

The first step is preparing the learner for feedback. To facilitate a smooth feedback process, set expectations with the learner early in the experience regarding the *content* that will be assessed and the *process* you will use to give feedback. Clarifying what you expect of the learner will ultimately save you time by minimizing learner confusion and mistakes.

In an initial orientation session, state your expectations of the learner's performance and discuss his or her objectives as well as the school expectations. During this initial orientation, let the learner know that feedback will be an integral part of the experience.

The learner is less likely to be "caught off guard" by your constructive criticism if he or she is expecting feedback.

Describe your feedback process and discuss with the learner when feedback will be given: for example, in response to shift report, directly observed encounters, debriefings at the end of each day, and/or in weekly reviews.

Ask about the learner's prior experiences with feedback (were they negative? positive?) and keep these in mind as you start giving the learner feedback.

Train the learner to receive and make use of your feedback. Giving learners a one-page "**instruction sheet**" (See Addendum 1) on receiving feedback (Rider & Longmaid, 1995a) can facilitate this orientation process.

MAKE A FEEDBACK-FRIENDLY ENVIRONMENT

You want to create a climate in which it will be easier for the learner to receive feedback. You can take several concrete steps to foster this environment:

- Show your *interest* in the learner's development. Ask about his or her background and future career goals, and show the linkages between the experience and these goals. Learners are less likely to feel threatened by feedback from someone who seems supportive than someone who seems to be judging them.
- Make it clear that you and the learner are partners working towards *a common goal* of expanding his or her clinical knowledge. Seek the learner's input as you discuss objectives for the experience and as you assess his or her performance.
- Show your interest in *what the learner does well* and on what he or she can improve upon. Because some learners may associate feedback only with criticism, it is a good idea to make some of your initial feedback positive.
- Show that feedback is a *natural part* of the clinical experience. Let the learner see you giving and receiving feedback from colleagues, staff, and patients. Regularly ask for the learner's feedback about your precepting and the experience overall.

PRIORITIZE WHAT FEEDBACK TO GIVE

Identify what priority points you want to focus the feedback on. If you provide too much feedback (more than four or five comments), it will be hard for the learner to retain any of it. Is the feedback that you are planning to give something that the learner can use to improve his or her future performance? Saying to a new learner, "You seemed really nervous in there - you were fidgeting a lot and your questions were all over the place" may not help the learner, unless you can add some concrete suggestions for how he or she might act differently in the future. Some behaviors are easier to change than others. For example, a learner's quiet nature or accent is not going to change overnight. However, if it is inhibiting communication with the patients, it is important to address.

It is best to give feedback immediately following an encounter, while the experience is still fresh in the learner's mind. However, if the learner is feeling rushed, upset, or otherwise distracted, he or she may not be able to concentrate on the feedback. You might tell the learner you have some feedback and suggest a time to talk later in the day.

The technique of "sandwiching" criticism by starting and ending with positive comments may help initially; however, be wary of using the same technique all the time. Some learners report that as they figure out the pattern, they begin to discount the positive feedback as "mere sugarcoating" of the criticism.

RESPOND TO LEARNER'S SELF-ASSESSMENT

Before you share your assessment, have the learner assess his or her own behavior in the encounter. Learners are less likely to be defensive if they critique themselves first, and you can then incorporate their observations into your feedback. This method also gives you a sense of their self-assessment skills. You might say: "Let's talk about how that went. What did you like? What would you want to do differently next time?"

OBJECTIVE OBSERVATIONS

Describe Specific Behaviors Observed

Base your feedback on direct observations of the learner. When you describe what you have witnessed, there is less room for inferences and interpretations than when you report what you have heard from someone else.

As you begin to give your feedback about the encounter, describe the specific action you observed, without any interpretation of the learner's assumptions or intentions.

VALIDATE POSITIVE BEHAVIORS OR SUGGEST ALTERNATIVE STRATEGIES

It is important to reinforce positive behaviors and provide positive feedback.

ESTABLISH A PLAN

- ***Make A Plan To Improve Performance In Weak Areas***
What does the learner need to learn or do differently next time? What strategies can you suggest to help the learner acquire this knowledge or change the behavior?
- ***Have Learner Summarize Feedback and Plan***
To make sure the learner has heard your feedback and synthesized it, you should ask him or her to summarize what has been said.

The "IMPROVE" strategy can make it easier for you to provide effective feedback. It helps you prepare a learner for feedback and provide specific information geared to improving future performance.

- ***Finding Time for Feedback During the Day***

We have discussed the need to provide feedback as promptly after a specific encounter as possible. But how do you do this, given your busy schedule? Your feedback to directly observed encounters throughout the day could be **brief** - prioritize 2-3 key points.

However, you do want to give more extensive feedback on a regular basis. It can help to **set aside 15-20 minutes each day** to review and go over feedback and teaching points in more detail.

- ***Location***

Where should feedback occur? The rule to follow is "praise in public and provide constructive criticism in private." With this rule, the learner is less likely to be defensive.

SUMMARY

Feedback is a critical component of clinical education; it helps learners learn faster and helps preceptors both teach and evaluate more effectively. Learners want more feedback than they usually receive.

Giving feedback does not have to take a lot of time or alienate learners. To facilitate a smooth feedback process, set expectations with the learner early in the experience regarding the *content* that will be assessed and the *process* you will use to give feedback. Base your assessment and feedback primarily on learner behaviors that you observe yourself. Make sure that the feedback you give is prompt, frequent, limited to a few priority issues that the learner can act on, objective, worded in a thoughtful way, and balanced with both positive reinforcement and constructive criticism. The "IMPROVE" strategy can help you remember these steps.

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Addendum 1

LEARNER HANDOUT ON RECEIVING FEEDBACK

The purpose of feedback is to gather information about your performance in a given activity in order to improve. Receiving feedback is an instrumental part of learning. Learners who receive regular feedback about their performance perform significantly better, develop better judgement, and learn faster than those who do not.

Yet receiving feedback can sometimes feel awkward or threatening. There are steps you can take to be an active partner in making sure the feedback you receive helps you improve your medical knowledge, skills, and attitudes:

Identify goals for yourself for this rotation, discuss them with your preceptor, and develop mutually agreeable rotation objectives.

SET THE STAGE:

- Consider feedback as an opportunity for growth rather than a threat of criticism.
- Identify goals for yourself for this rotation, discuss them with your preceptor, and develop mutually agreeable rotation objectives.

SEEK FEEDBACK:

- Assess your progress according to the rotation objectives you set.
- Ask for feedback on your progress in these particular objectives – both in daily encounters and periodic reviews.
- Seek feedback on what you are doing well in addition to areas you can improve.

RESPOND TO FEEDBACK:

- If a preceptor approaches you with feedback at a bad time (when you are feeling rushed or stressed), set up an alternative time, and follow up.
- Ask for specific examples if your preceptor has not offered them.
- Seek clarification on points that are unclear. Summarize the feedback at the end of the discussion to make sure you have understood the feedback.
- When receiving constructive criticism, discuss strategies to improve your weaknesses, and make a concrete plan to implement those strategies. Set up a time to revisit your progress.
- If you feel criticism is due to a personality conflict between you and a preceptor, talk to a friend or trusted adviser.

Source: adapted from Rider, E. A., & Longmaid, H. E. III. (1995). Feedback in clinical medical education: Guidelines for learners on receiving feedback. *JAMA*, 274, 938i. Cited with author's permission.

MODULE 3

AVOIDING

PROBLEMS

PREVENTION OF PROBLEMS

INTRODUCTION

The vast majority of learning encounters proceed smoothly with significant benefit for the learner and often a sense of reward and accomplishment for the preceptor. On an occasion, however there is a learning situation where things do not run smoothly. This is usually the result of many different factors involved in the interaction of individuals in a complex health care educational system.

The truth is that the vast majority of times things go just fine. An additional truth is that sometimes they don't. We hope that this module will help prepare you to prevent potential problems and to deal more effectively with problems when they occur.

Upon completion of the module, the participant should be able to

1. Describe strategies to prevent problems before they occur.
2. Discuss how to detect potential problems early.

PREVENTION

The old adage "an ounce of prevention is worth a pound of cure" is as true as clinical teaching as it is in clinical practice. It is generally much more efficient (and pleasant!) to prevent a problem than to manage the negative impact one it has occurred. Approaches to prevention in teaching can be divided into the categories of primary, secondary and tertiary prevention (Table 1). In education, as in nursing, the different kinds of prevention are similar.

For primary prevention the goal is to totally avoid the problem before it occurs. In secondary prevention the goal is to detect an issue early and act decisively in order to minimize or eliminate the effects. Tertiary prevention is the management of existing problems in order to minimize the negative impact of those problems. Each level of prevention has its own characteristics and strengths.

PRIMARY PREVENTION

As in nursing, the prevention of problems or issues before they occur is the ideal. Fortunately there are several strategies that can help prevent difficult preceptor/learner interactions. Many of these are related to issue of expectations: those that the school or program has for the experience, the learner's expectations for the rotation and your expectations for the learner's role and behavior during the time you are working together.

Table 1

PREVENTION
PRIMARY: Prevent the problem before it occurs. Know the experience expectations. Orient the learner well. Have clear expectations and goals. Determine the learner's goals and expectations Reassess halfway.
SECONDARY: Early Detection Pay attention to your hunches/clues. Don't wait. Initiate SOAP early. Give specific feedback early and monitor closely.
TERTIARY: Manage a problem to minimize impact. If it ain't working"...SEEK HELP. Don't be a martyr. Do not give a good evaluation to a learner who has not earned it.

As the preceptor, you should know the specific expectations for the learning experience. At times they may be non-specific and allow the preceptor a large degree of latitude in structuring the experience. At other times the expectations may be very specific in the learning objectives. You should know any specific expectations before agreeing to precept and then review them at the beginning of the experience with the learner.

An important step is a detailed orientation of the learner and a part of this is to make YOUR specific expectations known to him or her. What time does he/she need to arrive? What format do you prefer in his/her notes? What is the dress code? These and many other issues of value to you and your facility vary significantly from site to site and should be specifically addressed with the learner from the beginning. A clear understanding of the expectations and goals can help the learner adapt to your environment and avoid significant problems.

Learners also bring their own expectations to a rotation or learning experience. They may expect a certain level of responsibility or be counting on clinical experiences that are not available in your practice situation. Detecting any mismatches early can allow you to inform them or negotiate options before problems develop. By the same token, knowing the learners' individual desires, goals and expectations will help you to make this a more successful experience for them.

Even if a good orientation and discussion occurs at the beginning of the rotation, new or unanticipated issues can develop for the preceptor and the learner once the experience is underway. A formal opportunity to sit down together halfway through the experience creates an opportunity to reassess and refine goals and expectations for both the preceptor and the learner and can set the stage for an even smoother second half of the experience.

SECONDARY PREVENTION

If primary prevention has not succeeded, then the goal of the preceptor is to detect the issue as early as possible and act decisively in order to minimize or eliminate the effects. Just as early detection is key in the management of health problems, it is crucial in the effective management of difficult preceptor/learner interactions. Early detection identifies educational problems early and allows for early intervention and a better outcome. Even if an educational problem cannot be eliminated, early detection can help minimize the negative impact on you, staff, patients, and the learner.

The Secondary Prevention outlined in Table 1 is dependent on awareness that things can go wrong. Teachers and preceptors of health professionals are often optimists in dealing with their learners. They have come to expect high quality learners that they are able to interact with in a positive and pleasant way. As a result, early warning signs of difficult interactions are often ignored, downplayed, or attributed to "a bad day" or other circumstances. It is crucial for the preceptor to pay close attention to these "hunches" or feelings that things may not be quite right.

Additional "clues" can come from the comments or opinions of staff. For example, when a staff member who has previously interacted well with other learners begins to comment negatively on the current learner on the unit, this could be an important warning sign. Every "red flag" (or even yellow flag!) should be evaluated, just as attention should be paid to every abnormal vital sign. Not all will reveal an underlying serious problem, but serious problems could be missed if you are not systematic in looking at these warning signs as a potential indicator of significant issues.

Do not use "wait and see" as the only way to monitor potential issues. You may want to bide your time and to sit back and observe. "Well, maybe this is a problem but it's just the first week and we've been kind of busy. I'll just watch for a while." An excuse for one week leads to another and before you know it the problem has grown or it is near the end of the experience and there is not time to intervene. In the educational setting, you must examine and address potential issues as early as possible due to the limited time of the contact. "Wait and see" can be costly and ineffective in a short educational experience.

Plan to institute an organized assessment of a potential problem situation early. In the module "Management of Difficult Problems" we introduce the "SOAP" method for assessing educational situations. The earlier you begin looking critically at the situation, the more likely it is to succeed.

Not all situations require an immediate full assessment. When a problem appears minor, the preceptor can give specific feedback on the issue to the learner and then watch carefully to see that feedback is acted upon. The key step is the follow up – monitoring closely for a limited time. If there is no longer a problem, then only continued monitoring is needed. If the problem behavior continues, then a very careful assessment needs to be made as soon as possible. Note that this is a very different strategy from "wait and see". A brief active intervention is made and a brief period of observation follows. The chance of problem issues slipping through undetected is minimized. The judicious use of quality feedback and close follow up is invaluable.

TERTIARY PREVENTION

Sometimes in education as in nursing, a significant problem can arise despite the best efforts and intentions of the preceptor, facility, and school. Preceptors often see it as a personal defeat or failure if they are having a problem with a learner. Nothing could be further from the truth. Course directors know that there will be an occasional difficult situation and are prepared and waiting to assist you. Seek help early and discuss your concerns with someone who will understand.

Avoid the temptation to say, "Well, I'll just stick this out. There are only a couple weeks left." This does nothing to alleviate the negative impact of the problem on you, your staff and patients and does not help the learner. If you have been trying all the tricks and techniques that you know and are still not making any headway, then it is time to get help.

You do not need to be a martyr. Preceptors often feel that they have made a commitment to work with the learner through the entire rotation or experience no matter what. When a situation is having a significant negative impact on staff, patients, or family, then it is important to recognize that and to seek help in managing it. You are more valuable to the school, facility, profession, and future learners if you seek help early rather than burn out over one bad experience.

It is important not to give a good evaluation if you do not feel the learner has earned it. One of the characteristics of the profession and a professional is self-governance. You have a duty to prevent someone who may not be able to serve the profession well from being passed along without important issues or concerns being addressed. Communication of your concerns is important. A call to the course director or contact person for the experience can help you decide an appropriate course of action; as well as communicate your issues or concerns. Please give the evaluation that was earned so that the learner's performance and abilities are accurately reflected.

PREVENTION: A SUMMARY

Prevention is a key component of teaching and precepting. Using sound educational techniques for setting expectations, providing ongoing feedback, and doing a thoughtful, objective evaluation can prevent many potentially difficult situations. Other issues can be detected early by being alert for and paying attention to the hunches and clues that may indicate a subtle or developing issue. At times, despite everyone's best intentions, a significant problem may occur and careful management is required.

The module Management of Difficult Problems will outline a strategy for the assessment and management of the problems you detect. However, as mentioned earlier in this learning module, primary prevention (preventing problems before they even occur) is preferable to having to detect or manage problems after they are established.

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MODULE 4

SURVIVING DIFFICULT SITUATIONS

MANAGEMENT OF DIFFICULT PROBLEMS

INTRODUCTION

Although Prevention may be the best medicine, there are times in medicine when problems occur and management is needed. The same is true in teaching and precepting. A careful approach to orientation, setting expectations, and providing ongoing feedback can help prevent a lot of problems on those rare occasions when a problem develops. If you have been involved in a difficult precepting situation in the past, then you are well aware of this fact. If you have yet to encounter a difficult situation in your precepting, you are smart to consider that possibility and to prepare for that possibility.

Upon completion of this module you should be able to:

1. Describe an organized approach (SOAP) to the assessment and initial management of challenging preceptor/learner interactions.
2. Apply the SOAP model in the management of difficult precepting situations.

So you have paid attention to early warning signs and despite your best effort at primary prevention you think there is a problem... How do you begin? We recommend a SOAP format. This approach, adapted from Quirk (1994), is outlined in Table 1. In a step-by-step fashion, it allows you to work from basic data to objective assessments to a nursing diagnosis and a plan of action. We will now examine each step in detail.

SOAP – SUBJECTIVE

In assessing a potential difficult preceptor/learner interaction the subjective is usually the “chief complaint.” What was it that made you consider that there may be a problem with this interaction? Often the first indication that there may be a problem is when a learner is “labeled” by you or someone on the unit. When a learner is described as “slow,” “uninterested,” “angry,” “lazy”, etc., this can be an indication of an underlying issue that needs assessment.

Once you have a “chief complaint” then the history should be fleshed out. What do others in the practice arena think of this learner and his or her performance? When staff has had experience with several learners, they can be insightful assessors of learners’ interpersonal skills. Learners will often act differently towards staff or patients than toward the preceptor who will be grading them. As a result, your staff’s observations may not completely match your experience. Obtain data from all readily available sources and then determine if a pattern of behavior exists.

Table 1

SOAP – An Approach to Problem Interactions	
Subjective	What do you/others think and say?
Objective	What are the specific behaviors that are observed?
Assessment	Your nursing diagnosis of the problem.
Plan	Gather more data? Intervene? Get help?

Another source of data is the learner. Are they aware that there is a problem or potential problem? A simple question about how they feel things are going may reveal that the learner is aware of an issue and is working to remedy it. For example, a learner who has been 20 minutes late to clinical twice in the first week is asked, “How are things going with the rotation? I’ve noticed that you have been late a couple of times to clinical this week.” The learner apologizes and reports that the clock radio he/she bought is not working and he/she plans to go to the store to buy a battery-powered alarm clock after clinical today. Awareness of the issue by the learner is an important step in improving a problem behavior. Lack of awareness of an issue may indicate a more significant issue and/or the need to be more direct.

These labels and impressions should not be considered the “diagnosis” of the problem. Just as “fever” is a symptom of an underlying condition, these impressions or descriptions may just be symptoms of a more specific underlying “diagnosis.” In teaching, as in clinical practice, it is important not just to recognize and treat symptoms but to determine and act on an appropriate diagnosis. More specific information will be needed.

SOAP – OBJECTIVE

Once information is available on a general pattern of behavior or a general description of a pattern of interaction, it is essential to then identify and list specific instances of behavior to try to document the issue(s). It is very important to be able to describe specific instances of behavior to the learner. The learner who is unaware that his or her actions or attitudes were likely to trigger a concern may have difficulty reviewing his or her performance to determine exactly what behaviors or episodes are responsible. You will need specific information to intervene effectively. (Table1)

The following are examples of specific behaviors that you might list:

- a. "More than 20 minutes late to clinical on Monday and Tuesday this week."
- b. "Took forty minutes to assess the postoperative patient on Monday afternoon."
- c. "Spoke harshly to unit secretary when asking her to check on lab results Tuesday."
- d. "Unable to recall info on medication interactions after we had reviewed it on Tuesday at lunch."

Having a list of specific behaviors and specific instances of behavior (preferably written down) will be extremely important in helping you to make your assessment of the nature the problem and later to decide on and initiate your plan of action.

SOAP – ASSESSMENT

The next challenge is to analyze the information from the Subjective and Objective parts of your assessment and to try to determine what the possible causes are – to work from the symptoms and manifestations of the problem to determine a diagnosis. Nurses are highly effective at considering a wide range of possible explanations when making a nursing diagnosis. Unfortunately we are less confident when it comes to assessing learning situations. This comes not from an inherent inability but from the lack of practice and experience. Just as the clinical learners you precept produce short and sometimes incomplete assessments for clinical problems, we tend to come up short in our assessment of potential sources of learning difficulties. With practice and a little help we can produce an accurate assessment of learning issues as well. A guide to potential diagnoses for difficult preceptor/learner interactions is listed in Table 2.

COGNITIVE

One diagnostic category for learning difficulties is the Cognitive area. Does the learner's knowledge base or skill base seem less than you expect for a learner at this level? It is possible that it reflects a true deficit in their preparation. It could also be that the learner has not had the same preparation as other learners you have precepted. Learners of different levels of training or from different schools or programs may have markedly different levels of preparation.

Another explanation is that the learner may have a learning disability. Dyslexia, spatial perception problems, communication skill deficits and attention deficit disorder have all been diagnosed for the first time in health care professions students². Do not make assumptions. A learner in a demanding professional training program may have a learning disorder that has gone unrecognized. Learners can develop highly effective coping strategies that work in the classroom, only to find that these same strategies do not work in the unique demands of the clinical learning environment.

A student may lack sufficient interest or motivation in your clinical area. A student who wants to work in long term care, may not be highly motivated to excel in your specialty area. By the same token, a student who is headed toward a career in a specialty care area, may not fully appreciate the learning opportunities in a general medical-surgical experience. Lack of motivation may not be a diagnosis in itself but could be a symptom of an underlying process. As a result this should be a diagnosis of exclusion and all other reasonable possibilities considered and excluded; otherwise an important issue may be missed.

Table 2

ASSESSMENT	
Cognitive	Knowledge base/Clinical skills less than expected? Dyslexia? Spatial Perception Difficulties? Communication difficulties? Lack of effort/interest?
Affective	Anxiety Depression Anger Fear
Valuative	Expects a certain level of work Expects a certain grade Does not value the rotation Does not want to be at your site Does not value your teaching Holds principles that conflict with those of your or your patients
Environmental	Hospital-care oriented Not time-sensitive Not patient-satisfaction oriented
Medical	Clinical depression Anxiety disorder/panic Recovering from recent illness Hypothyroidism Pre-existing illness in poor control Psychosis Substance abuse
Psychosocial	Single parent Lack of financial support Working too many hours outside of school

AFFECTIVE

A second category of possible “diagnoses” is Affective or emotion-related concerns (Table 2). New learning situations frequently result in significant initial nervousness and *anxiety*. Severe anxiety can be a crippling emotion and extreme nervousness can markedly affect performance. It is important to separate normal nervousness from a more significant problem. Does the anxiety manifest itself only in specific situations or is it more generalized? Is the nervousness improving quickly, as the learner becomes familiar with your setting? Does it respond to reassurance and encouragement or does it seem to worsen? Is the anxiety having a negative effect on the learner’s performance? Persistent or severe anxiety should not be ignored.

Depression can also severely affect performance. The depression may be a normal response to a life situation. A learner returning to school after a recent death in the family, divorce or a miscarriage may have difficulty in concentration and performance and other features of depression. Signs or symptoms of depression could also be the result of a major depressive illness that is discussed below.

Anger is an emotion that compromises relationships. The learner may have and display underlying prejudices or biases toward certain ethnic, social or religious groups. They may have and display a superior attitude toward staff and assistants. Anger may be a result of not having been assigned to a preferred site/unit. It is important to recognize anger and assess underlying causes early or it can have a significant effect on the experience.

Fear is a specific form of anxiety. Prior negative learning experiences may severely impair the ability or willingness of the learner to communicate openly with you. Early learners may be intimidated by patient contact: they may fear that they will not be viewed as a professional or be intimidated by the prospect of performing an assessment on a patient. Learners (and practicing clinicians) can sometimes be compromised in their work by the fear that they will harm a patient.

One strategy for determining if an affective diagnosis is present is to consider what emotion or affect the learner or learning situation produces in you. Do you feel anxious or nervous when you talk to the learner? Are you sad or depressed after a day of working together? The affect the learner produces in you can be an important clue to the affect of the learner.

VALUATIVE

The Valuative category of diagnoses is among the most common difficulties (Table 2). They are usually the result of a mismatch between the values and expectation of the learner and the preceptor. A learner may anticipate a light workload and may not expect the high volume and long hours that they find. A learner may have a primary interest in a different clinical area and may not perceive your area as valuable to his or her education. A learner may be too forceful in presenting his or her personal or religious values when taking with staff and patients, which can lead to conflicts. As discussed earlier, many of these issues

can be detected early or prevented by a thorough orientation, review of expectations or mid-rotation review. It is important to be alert for these common mismatches at all stages of the learning experience.

ENVIRONMENTAL

A marked change in the learning environment can affect the learner's performance. A learner who is used to hospital care may struggle in the outpatient setting and vice versa. A learner may be used to a well-defined specialty population and may be overwhelmed with the population in the general medical-surgical setting. Another learner may be used to the luxury of having lots of time with patients in one setting and may be frustrated by the time pressures of another clinical setting. Patient satisfaction is an important part of modern clinical practice. A new learner may not have fully integrated a strong concern for the patients' satisfaction in his or her approach to providing care while learning.

MEDICAL

At times a Medical diagnosis may be at the root of an educational issue. Here the clinician's knowledge of illness and its manifestations can be helpful in considering possible medical causes of learning difficulties. Anxiety or depressive symptoms may be the normal response to a life event or situation as discussed in the Affective section. Sometimes a learner may present with a full-blown *major depression* or *anxiety/panic disorder*.

A recent illness such as mononucleosis or pneumonia may affect performance, as may a *previously undiagnosed illness* such as hypothyroidism.

A pre-existing illness such as diabetes or an eating disorder that is now in poor control can lead to difficulties in the clinical setting.

Mental illness, such as schizophrenia, may present with *psychosis* in a previously healthy learner.

Health professional learners are at high risk for *substance abuse* as are health professionals. A healthy suspicion for substance abuse should be maintained when erratic or substandard performance is present.

The Medical Assessment step (Table 2) can seem daunting but there are two important facts to remember. As a health care provider you are trained to make nursing diagnoses, and the same skills you use to develop a diagnosis on a patient will work with learning difficulties. Also, it is not necessary to have a firm diagnosis in hand to determine a plan and to get the help you need.

SOAP – PLAN

At this point you have determined that a difficult situation exists, you have collected subjective and objective data and you have developed a working diagnosis. Your next step is to decide on a plan (Table 3). Your plan of action must be highly dependent on your diagnosis and the impact of the situation on you, your practice and the learner. The following are possible courses of action.

Table 3

PLAN
Gather more data? <ul style="list-style-type: none">Observe and recordDiscuss with learnerContact School
Intervene? <ul style="list-style-type: none">Detailed behavior-specific feedbackSpecific recommendations for changeSet interval for re-evaluation
Get help? <ul style="list-style-type: none">Get assistance from supervisor or school

GATHER MORE DATA

For a mild situation where the current negative impact is minimal and further assessment has not uncovered more serious problems, an approach may be to gather more data. You may need more information in the OBJECTIVE area of your SOAP process in order to produce a more accurate diagnosis. *Observe and record*: more behavior-specific data from direct observation and colleagues can help you decide on a next step. This data will be of value in planning your own intervention or in communicating your concerns (Table 3).

Consider *discussing the issue with the learner*. Even at an early stage in your assessment of the situation, this could shed additional light on the issue, including the learner's awareness of the issue and potential causes.

You may want to contact the school at this point – even for what appears to be a relatively minor concern. They can be a source of excellent advice and guidance as well as moral support.

INTERVENE

Difficult learning situations that seem straightforward and are having minimal impact on the unit, the staff and patients may be amenable to intervention in the practice setting. If the problem falls into a category that may be remedied by educational intervention (such as a Valuative or a mild Affective issue), an attempt at intervention may be very appropriate. Detailed specific feedback is the cornerstone of your intervention. The detailed observations you have made will identify your areas of concern for the learner and will allow you to make specific recommendations for change. A set interval for reassessment should be determined so that a discussion of the learner's improvement (or lack of improvement) will occur. (See module on "Feedback" for more information). Many learners will be able to act upon good feedback and make dramatic improvement. It is important to recognize that if an intervention is not successful, the problem may be a larger one than you had thought and more help may be required.

GETTING HELP

Getting help should not be a last resort. As in clinical practice, an important first step is to carefully consider the seriousness of the situation and then decide on an appropriate plan. You must determine which issues can be appropriately addressed in your setting and when you would need additional resources. It is not the duty of the preceptor to solve all of the problems of the learner. As health care professionals you have strong desire to help others and to solve their problems. Nonetheless, your relationship with the learner is not a provider/patient relationship but a teacher/learner relationship. There are clearly some diagnoses in our Assessment for which additional resources should be used.

As mentioned earlier, contact with the school can result in additional information or may help you in selecting an appropriate intervention. The primary responsibility for the well being of the learner rests with the school or program and it has significant resources to help learners in need. In some of these cases it may not be appropriate for the learner to remain on your unit. *Transfer* back to the school or program should not be seen as a failure of the preceptor but rather as success for the educational system – for the learner to get what he or she most needs.

DEALING WITH THE DIFFICULT LEARNIG SITUATION:

PRECEPTOR ISSUES

To this point we have focused on issues related to the learner. There are times when difficult learner situations can occur due to preceptor-related issues (Table 4). Unanticipated events can have a significant effect on a planned teaching experience. Personal illness or an illness in family members may affect your ability to teach effectively. Sudden events such as the loss of key staff can markedly affect the ability of a unit to serve the needs of a learner. Unexpected financial or schedule-related pressures could upset a previously planned learning/teaching experience.

At times, an unanticipated personality clash with a learner will make it impossible to establish the necessary close working relationship of the learner and preceptor.

Most clinician teachers/preceptors do not take their commitment to teach lightly and will often try to work through unexpected difficulties and personal issues. There are two important questions to ask when preceptor issues are present:

- 1) Is the presence of the learner preventing you from doing what needs to be done?
- 2) Are your issues seriously affecting the education of the learner?

Often there is a strong tendency to ignore problems and their impact rather than consider declining to take an agreed-upon learner. The result of this could be a LOSE/LOSE situation for the preceptor and the learner.

Table 4

PRECEPTOR ISSUES THAT MAY AFFECT TEACHING
Health Issues: Personal, family
Practice Issues: Staffing, over-scheduling, financial issues
Relationship Issues: Personality clash with learner
Important Questions: Is the presence of the learner preventing you from doing what must be done? Are your issues seriously affecting the education of the learner?

Despite the best laid plans there are times when personal or professional issues of the preceptor, and not the learner, may be a cause of a difficult learning situation. It may **not** be in the best interest of the learner (or the preceptor) to try to complete a rotation in the face of these situations. The presence of the learner may make it more difficult for the preceptor to deal with their situation. When faced with a personal or professional crisis, the preceptor should ask him/herself if his or her issues are negatively affecting the education of the learner and if the presence of the learner is keeping him or her from doing what must be done.

CONCLUSION

This learning module has focused on the identification and management of difficult learning situations. It is important again to put things back in perspective and to remember that the vast majority of times learner/teacher interactions go along just fine. It is only rarely that significant problems develop.

The careful application of the prevention techniques discussed in the Prevention learning module can further reduce the occurrence and impact of difficult teacher/learner interactions. Maintaining a vigilance to help detect issues early and applying the SOAP approach to assessing and intervening early can reduce the impact of the occasional difficulty.

When the rare significant problem occurs, it is important that you seek help early and not allow one experience to burn you out as a preceptor. Getting the resources needed for the learner as soon as possible benefits you, the learner and future learners that you will be able to teach.

REFERENCE

Quirk, M. E. (1994). How to Learn and Teach in Medical School: A Learner-Centered Approach. Springfield, IL: C.C. Thomas.

MODULE 5

MEANINGFUL

EVALUATION

EVALUATION: MAKING IT WORK

INTRODUCTION

Evaluation is a valuable process that begins before the experience starts and integrates fully with the entire learning experience. The result of a well-integrated evaluation process is an enhanced learning experience and increased satisfaction. Integrating evaluation into the entire experience and linking it with other important teaching skills, such as setting expectations and providing effective feedback, can actually make a difficult task easier and more effective.

Many find evaluation to be an unpleasant task. They enjoy teaching, but dislike having to “grade” their learners. The occasional difficult situation can leave an unpleasant aftertaste. If evaluation was just “giving a grade” it would hardly be worth it for anyone. By consciously and conscientiously integrating the evaluation process into the entire learning experience, you can simultaneously enhance the quality of the educational experience and avoid or minimize the potential discomfort of the process.

Upon completion of the module you should be able to:

1. List characteristics of evaluation and discuss why it is important.
2. Discuss pitfalls in the evaluation process.
3. Outline a practical system for effective evaluation.

EVALUATION: WHY IS IT IMPORTANT?

There are three key reasons for effectively evaluating those that you precept. First, evaluating learners is a basic expectation of teaching. Almost every school expects some type of report or form completed on learners that they send to you to precept. Although the level of detail and complexity may vary depending on the experience, some expectation for evaluation is implied when you agree to work with a learner. Evaluation is a critical function of the role of “teacher/preceptor.” Just as your chemistry professor was obliged to give you a grade, you are expected to evaluate the learners that you precept.

Many preceptors volunteer their time and energy to precept because of a sense of wanting to return something to the profession and to play a role in the future of nursing. Accurate and meaningful evaluation is a key component of that role. By evaluating learners, you are helping to judge future members of your profession to see if they possess the appropriate knowledge, attitudes, and skills for their level. You are modeling for the learner how to assess his/her current strengths and weaknesses in order to continue their professional growth and development.

Finally, effective and ongoing evaluation can enhance the quality of the learning experience, as well as setting the stage for future professional growth. When integrated into the entire learning experience the evaluation process can enhance the educational value for the individual. Developing a strategy and a system for accomplishing this is a primary goal of this module.

EVALUATION: WHAT IS IT?

Many persons think of evaluation as the brief meeting at the end of a learning experience, but this is only a small part of the picture. This *evaluation session* is a scheduled, formal session between the learner and preceptor. The content should be based on objective data, and from personal observation. The *evaluation session* takes only a small proportion of the time relative to the length of the learning experience, but requires a significant amount of background to be valid and effective.

The *evaluation process* is an ongoing series of steps and interactions that form the foundation for the information that you share in your evaluation sessions. This process should be fully integrated into the entire rotation. The complete educational experience—from program expectations to ongoing observation and behavior-specific feedback – all these components are part of the evaluation process. An awareness of evaluation should be maintained throughout the experience.

One component of evaluation is *assessment*. Although often used interchangeably with evaluation, the two words have different meanings when applied in education. Assessment is the on-going process of collecting information about the learner's current level of knowledge, skills and attitudes. In your daily work with the learner, you are continually becoming more aware of his or her level of knowledge. In this way, you identify areas where the learner needs to improve. Think of assessment as “an educational diagnosis” for the learner. Based on this educational diagnosis you are able to provide ongoing feedback to the learner. When summarized over a period of time and analyzed in terms of improvements made, your assessment is the basis for your evaluation. An accurate ongoing assessment is the basis for effective feedback and a functional evaluation.

Feedback is the act of providing the information for your ongoing observations and assessment to the learner. It is best if it is very specific to the behavior observed and given as close in time to the event as possible. Feedback is an important educational tool, but feedback and evaluation sessions are sometimes confused. They differ in several important areas (Table 1). Feedback is best if it is “Timely” – given as close to the learning situation as possible. Evaluation sessions are usually a scheduled event at a specific time. Feedback is often informal – fit in at appropriate, brief sessions, into a busy workday. Evaluation sessions are usually performed in a more formal setting by sitting down for a more “official review.”

Table 1.

COMPARING FEEDBACK AND EVALUATION SESSIONS		
	FEEDBACK	EVALUATION
Timing	Timely	Scheduled
Setting	Informal	Formal
Basis	Observation	Observation
Content	Objective	Objective
Scope	Specific Actions	Global Performance
Purpose	Improvement	“Grading” & Improvement

There are some important similarities between Evaluation and Feedback. The basis for both feedback and evaluation should be objective data – specific behaviors that you observed. The scope or focus of feedback is on specific events or actions, whereas evaluation should encompass a broader review of performance and skills.

The underlying purposes of feedback and evaluation may seem to be very different IF the emphasis of evaluation is solely to generate a “grade.” As you progress through this module, you will see that an integrated approach to evaluation makes it an important tool for enhancing learning and professional growth.

EVALUATION: WHAT CAN GO WRONG?

One of the challenges of evaluation is that, without careful attention, a well-meaning preceptor can find himself or herself in an uncomfortable and unpleasant situation. There are a number of things that can go wrong. Some potential problems and pitfalls are listed in Table 2.

Table 2

POTENTIAL PROBLEMS WITH EVALUATION
<p style="text-align: center;">“Halo Effect”</p> <p style="text-align: center;">“Oops” – Insufficient Evidence</p> <p style="text-align: center;">“You never told me that!”</p> <p style="text-align: center;">“But I NEED a high grade!”</p> <p style="text-align: center;">“Uh –Oh” –Should they pass?</p> <p style="text-align: center;">“Lake Wobegon” Effect</p>

The “Halo Effect” can make giving a realistic and practical evaluation difficult. The term refers to the situation where one unrelated but outstanding characteristic has an effect on other aspects of evaluation. For example, a learner who is very nice, friendly, outgoing and well liked by staff but clinically mediocre could get a very good evaluation. Likewise, a quiet, reserved, introspective but clinically excellent learner could receive a mediocre evaluation. It is important to look beyond personality traits and consider the entire package of underlying knowledge, attitudes, skills, and performance when evaluating the learner.

At times a preceptor will arrive at the end of the experience with a sense that a learner’s performance is inadequate in some areas, but is not able to recall the details to specific instances where this was demonstrated. This makes it challenging to explain to the learner why a certain area was evaluated as it was and what specifically could be done to improve. Paying close attention to specific instances of clinical performance, and having a system for recording them, will greatly assist the preceptor in doing an accurate evaluation and explaining it to the learner.

The preceptor often has certain standards of performance in mind against which each learner is compared. If these standards are discussed with the learner for the first time at the final evaluation, the preceptor is likely to hear, “But you never told me that!” It is important to discuss your evaluation criteria as early as possible in the clinical experience and to give ongoing feedback on areas in need of improvement. For example, you may expect a learner to read specific materials. You should state this early in the experience and periodically ask the learner what he or she has learned from the reading. If you determine the learner is not meeting your expectations in this area, specific and clear feedback should be given with examples of what was done. When you arrive at the final evaluation session, your assessment of how the learner has met or not met your objectives will be well supported.

Most learners are primarily focused on their professional growth and development, but some bring expectations for a particular “grade” or evaluation to the experience. The final day of the experience is not the best time to become aware of these goals and perceived needs. An early discussion of the learner’s goals and expectations for the experience will allow a process of helping the student to meet the goals or facilitate understanding of why it will not be possible to meet the goals.

Occasionally the preceptor will arrive at the end of the clinical experience with the realization that, despite significant and sometimes heroic effort on the preceptor’s part, the student’s performance remains substandard. At the very end of the rotation the question is, “What do I do now?” The final evaluation is not the best time to begin contemplating this issue. If a learner appears marginal or problematic it is crucial to get help early. Contact the appropriate person immediately. Significant help and guidance is available and should be sought early.

A strategy that is sometimes used to make evaluations “painless” is brought to mind in the Prairie Home Companion radio show and the mythical town of Lake Wobegon: “Where all our students are above average.” Some preceptors consider that if they give all learners a high evaluation in spite of their performance, then everyone should be happy... Right?

Not exactly. The school, facility, and the learner are all misled and are unable to benefit from the opportunities for growth and improvement that an accurate evaluation can provide. The evaluator has abdicated his or her responsibility to the learner, to the school, to the facility, and to the nursing profession. Future patients and the profession, as well as the learner, will suffer as a result.

These are a few of many potential pitfalls. The good news is that most of these situations can be consistently avoided, making evaluation a useful educational tool rather than an uncomfortable chore. Incorporating evaluation into the learning environment from the very beginning of the experience is essential.

EVALUATION: MAKING IT WORK

The key to avoiding evaluation pitfalls is to recognize that Evaluation is not just something that you do for an hour at the end of the experience. It is vitally linked to the entire experience. When this connection is lost or ignored, problems are more likely to occur. Integrating evaluation throughout the experience will make evaluation easier, more productive and will help to have a positive educational effect. Our **G-R-A-D-E** strategy can help you accomplish this (Table 3). We will review each component in detail.

At the beginning of the experience, discuss how you plan to evaluate the learner. Review the evaluation form and the criteria used. How and when do you plan to give ongoing feedback? When will the evaluation sessions occur? This early meeting and discussion with the learner sets the stage for a productive learning experience that is more likely to be free of unpleasant surprises for anyone.

GET READY

One of the most difficult, but perhaps one of the most important parts of the evaluation process is “getting ready.” The challenge comes from the fact that this is best done before the learner even arrives. Before you first meet the learner, review a copy of the course objectives and the evaluation form. Even if you have had learners for the same clinical experience before, a review of the objectives and a review of the evaluation criteria can help you focus on the learning opportunities available on your unit.

REVIEW EXPECTATIONS WITH THE LEARNER

Now that you have determined the objectives of the school and your expectations for the learner, it is vital to review these with the learner. This should occur very early in the experience as part of an orientation meeting. The more specific you can be, the more likely the learner will be able to implement your suggestions and meet the requirements.

Table 3

The G-R-A-D-E Strategy for Evaluation
G ... Get Ready <ul style="list-style-type: none">- Review expectations- Review Evaluation Form- Consider unique Opportunities/Challenges of your area- What are the Expectations for the learner?
R...Review Expectations with learner? <ul style="list-style-type: none">- Meet very early in the experience- Determine knowledge/skill level- Review Goals- Describe the Evaluation Process-
A...Assess <ul style="list-style-type: none">-Observe-Record-Provide Feedback Regularly-Have Learner do a Self-Assessment
D...Discuss Assessment at Mid-Point <ul style="list-style-type: none">-Formal Meeting-Learner and evaluator fill out form in advance-Compare evaluations together-Discuss differences and how expectations are being met
E...End with a “Grade” <ul style="list-style-type: none">-Complete evaluation in advance-Schedule sufficient time-Support your evaluation with examples-Highlight items that can be worked on in the future

The *learner's* expectations should also be reviewed. What do they hope to get from the experience? Are there specific clinical experiences they would like to have or specific procedures they expect to learn or perform? Not all learners are up front with (or have even thought about) their own expectations, but this kind of questioning promotes adult learning style. Knowing their expectations up front can help you avoid potential problems and conflicts that can come from unrealistic or unmet goals.

The educational level and experience of the learner should be determined at this time. Knowledge base and skills can vary significantly from one learner to another and as a result, your expectations and interaction with the learner will need to be different.

ASSESS

By reviewing expectations, goals, and evaluation, you can now readily assess the learner's performance in an educationally productive manner. Remember that assessment should be an ongoing process throughout the rotation. The preceptor should compare the learner's performance to the program's expectations.

Observation is a key component of Assessment. Observing learner/patient interactions, clinical skills, and notes provides the basis for your evaluation. Important data from observation can sometimes be lost. Time passes quickly and useful details from the beginning of a rotation may be lost to memory by the end. A method for briefly recording observations may be helpful in remembering useful details. A note card in a pocket or quick notes slipped into a file folder can give the preceptor a quick way to jog the memory. These notes can be used to provide more specific behavioral feedback at the end of the shift and saved to help you remember at evaluation time.

Remember feedback is a key component of the evaluation process. Issues, concerns, or problems should not be saved up for the end of the rotation. Timely, directed feedback will give the learner the opportunity to try to improve. By the same token, positive comments on a good performance should not wait for a scheduled time. Few things reinforce good behavior and growth more than timely, positive feedback.

As a practicing professional, much of the "feedback" and "evaluation" of your day-to-day performance must come from self-assessment. Encouraging learners to assess themselves promotes this important behavior and gives you valuable data on how they view their own performance. Before giving your feedback, for example, ask the learner "How do you think your interaction with the patient went?" This can provide a new perspective to both the learner and preceptor.

DISCUSS EVALUATION AT THE MID-POINT

Time passes very quickly, but taking the time to do a mid-point evaluation creates a valuable opportunity to review the experience to date, detect any unexpected issues, and plan for the remainder of the educational experience.

It is important to schedule a specific time for this meeting. This separates this session from your ongoing feedback, and defines it as a summary of performance to date and an opportunity to plan for the remainder of the experience. A minimum of 30 minutes is usually needed to ensure adequate time for discussion.

Both the preceptor and the learner should prepare for the mid-rotation evaluation. If an evaluation form will be used for the final evaluation, make two extra copies. Fill out one in advance of your meeting and the learner should complete his or her copy before you meet. Filling the evaluation forms out separately avoids the chance of influencing each other's honest assessment.

The learner should be asked to consider how the clinical experience has met their needs and expectations so far and be prepared to discuss any suggestions for improvement.

Compare forms at the meeting and review the learner's evaluation to date. Areas of good performance should be highlighted and specific recommendations for improvement given. Significant discrepancies between the learner's and the preceptor's assessments should be discussed in detail. Unmet expectations should be discussed and a plan for improvement agreed upon.

This mid-point evaluation provides an excellent opportunity to shape the learner's growth and development for the remainder of the experience and to assess how well the learning experience is meeting the needs and goals of the learner. It also helps to identify situations where there is a significant difference in the evaluation of the learner and the preceptor. These discrepancies are best detected before the final evaluation. A relatively small amount of time and effort during the middle of the experience can dramatically improve the ultimate satisfaction of the learner and preceptor and avoid unpleasant surprises at the final evaluation.

END WITH A GRADE

After a great deal of discussion we've come to the final evaluation. You are prepared to provide a high quality evaluation with less effort because the process was begun early and you provided ongoing feedback and a mid-point evaluation.

It is important to schedule sufficient time for a formal, private meeting. Consider setting aside an hour. Take the opportunity to complete the evaluation in advance. This allows you time to carefully reflect on the learner's performance – their knowledge, skills and attitude, how they have improved during the experience and where there is room for further growth. It is difficult to do this effectively with the learner looking over your shoulder. Support your evaluation with specific examples (this is where your notes can be very helpful). Rather than saying, "You have a good rapport with patients," describe a specific instance where this was apparent. *Consider including examples on the written evaluation.* This can be very helpful to the school in giving them a clear picture of the learner's performance. It is important you are able to justify your final evaluation based on the actual performance of the learner.

Although this particular learning experience is ending, the learner's education and professional career will continue. Discuss how the lessons learned and the identified areas of improvement can be applied to the learner's future goals.

THE PAPER WORK

Like many other things in life and healthcare, "It's not over until the paperwork is done." In that spirit, we should spend a moment discussing this aspect of evaluation. Although there are many different evaluation forms, there are some important general principles that can be followed.

Paperwork Principle 1 – Be familiar with the form

The preceptor should review the paperwork before the experience begins. If there is any concern or confusion regarding the materials or your role in evaluation, get in touch with the appropriate contact person for clarification. Be prepared to discuss how you arrived at your evaluation with the learner and/or the school. Most of the time this level of discussion does not occur, but if you are prepared you have done a thoughtful and accurate evaluation. Specific examples of performance should be included whenever possible.

Paperwork Principle 2 – Write comments that support the evaluation

Many forms require or request written comments from the preceptor. These can be extremely useful to the school. Written comments help describe the details of a less than ideal performance and why a particular assessment is warranted. Comments should be as specific as possible – describing positive attributes and strengths as well as reviewing areas for improvement. The evaluation form should reflect the learner's overall level of performance.

Paperwork Principle 3 – Do it sooner rather than later

Complete any necessary paperwork as promptly as possible. It is surprising how quickly the memory of a learner and the details of their performance fade as the parade of life and practice move quickly forward. Completing the paperwork in advance of your final evaluation meeting gets most of the work out of the way before the learner has left and while the experience is still fresh in your mind. You can also reserve the last 10 minutes of your final evaluation meeting to wrap up any paperwork after the learner has left the room. Prompt completion of the required forms makes the process much easier.

EVALUATION – MAKING IT WORK

To summarize, evaluation is not just something done at the end of the experience. It is not just getting some ink down on paper. Evaluation is an ongoing process that begins before the learning experience starts and continues throughout the experience. When integrated into the clinical experience, the evaluation process improves the quality of the educational experience and contributes to the satisfaction of the learner and the preceptor. Utilizing the G-R-A-D-E approach helps accomplish this vital integration. Evaluation is a process for guiding and contributing to the growth and development of our future colleagues in the health profession.

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