Learner Difficulties in a Longitudinal Integrated Clerkship: a University of Alberta Experience

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Background: *Difficult learning situations occur in all clerkships. However, there are some unique opportunities in longitudinal integrated clerkships (LICs) to diagnose issues and to tailor coaching for the learner thereby avoiding the need for formal remediation if they failed to progress in a shorter rotation-based clerkship.*

With continuity of patient care, continuity of supervision and the continuity of learning environment/curriculum, LICs have the learning context in which to explore the issues and to develop solutions that will contribute to success for learners with all levels of knowledge, skills and attitudes.

Students of the University of Alberta ICC are under our direct observation for 40 weeks. In this time our experienced clinical preceptors, site visiting faculty colleagues, online teachers and the clerkship director have the opportunity to build a longitudinal assessment in which they deeply understand our learners' strengths and weaknesses.

The literature would support the notion that that learner difficulties are discovered during direct observation (82%) and critical incidents (56%). Learner difficulties are identified by preceptors (>74%) and learners rarely come forward themselves (2%). Additionally, frequent feedback sessions (65%) and assigned mentor for structured supervision (53%) are the two most helpful interventions for learners experiencing difficulty.(1)

Clinical Preceptors within a clinical clerkship must balance the skills of being a good role model while maintaining objectivity in order to identify learners with a variety of problems. Difficulties in learning often present in one of three areas: personal problems (of health, relationships, substance abuse, depression or mental health), core clinical incompetence (related to knowledge base, communication, clinical reasoning etc) and professionalism (defined here as a lack of respect and/or responsibility). (2)

This article primarily addresses perceived unprofessionalism - and dissects common behaviors that at first glance appear disrespectful or irresponsible. The relationship of the clinical coach and the LIC student often allow for these thorny issues to present, be understood and strategically improve over time.

Presenting Features *Direct Observation; Feedback from Team, Patient or Learner*	**Learner Difficulty**	**Strategy for Improvement**
Patients not experiencing rapport with the learner or getting upset with the learner. Learner not noticing patient or family-member distress. Learner asking contextually inappropriate questions	**Difficulty understanding patient context / building rapport:** Inexperienced in communicating with patients. Missing the meaning behind key statements or nonverbal cues. Immaturity.	Ongoing direct observation and specific feedback of your observations of the encounter, focusing on making meaning of what was said by the patient. Role model with clear explanation of how to uncover the patient's agenda.
Learner stands back in interesting clinical experiences, lets other learners or mentor to step in (to perform the procedure, task, communication)	**Apprehensiveness:** Lacking confidence, anxious or shy, uncomfortable with their role, assertiveness	Ongoing direct observation. Invite the student in, give them a clear task. Consider step-wise approach and give the learner time to rehearse.

Learner misses important clinical teaching opportunities as not prepared (e.g., not gowned and gloved at a procedure). Inattentive in observer role. Unprepared for scheduled patient care meetings, ward rounds, etc. Poor judgement of team dynamics. Understands patient diagnosis but not trajectory of their expected course in hospital and anticipation of clinical course.	**Difficulty with situational awareness and anticipation.**	Ongoing direct observation and specific feedback on their perceived lack of attention and responsibility in the context of the team and the schedule. Clear expectations of their role, how to communicate within the team. Teaching trouble-shooting and playing out the scenario, what could go wrong and what is the expected course. Understand the level of the learner. Are they still mastering reporting and integrating? Is management of the particular diagnosis expected at their level of learning?
Learner ready to prescribe management without considering the consequences in this context for the patient (side effect, age, weight, renal function, social circumstances)	**Missing context:** Sufficient Book knowledge but inability to incorporate to clinical context	Ongoing direct observation and role modelling of deliberate contextual management. Specific feedback around anticipation of problems that that might occur with the management in the given context and how to watch for these. Focusing on development of the Patient relationship: understanding patient context and patient factors that influence management and compliance. Put in context of the level of learner: Only a learner difficulty if they are below level of expected for their level of training and not improving with coaching and feedback.
Learner unprepared for scheduled events - ward rounds, team meetings. Expecting team members to inform them of where and when to be. Wanting clinical knowledge to come from the preceptor.	**Passivity:** Not taking responsibility for their own learning or as a team member	Ongoing direct observation and specific feedback; direct and clear instruction on expectations, deliver specific tasks and have set follow up for delivering completed tasks. Expect that the learner solicit feedback.
Learner presents tearful, withdrawn, inattentive, preoccupied, fatigue or struggling to complete tasks, absences	**Medical Illness,** anxiety, formal mental health diagnosis or relationship difficulties	Private formal meeting to assess the students' difficulties. Promotion of self care. Referral to Program resources, eg student affairs, or for medical evaluation
Inappropriate dress or clothing. Poorly legible handwriting or note structure. Personal hygiene issues. Not rested and ready for work.	**Poor self-care:** Attire, handwriting, self-care	Ongoing direct observation. Specific feedback in a conducive environment. The value of a longitudinal relationship is the ability to to give feedback in any area respectfully. Address these issues directly in a private setting. Promotion of self-care. Modelling of self-care by preceptor.

Not on time for scheduled events, not initiating or completing chart notes and admission notes. Bare minimum discharge summaries. Not establishing working relationships within the medical team and with ancillary staff.	**Poor initiative:** Irresponsible in communication and collaboration, Tardy attitude, lack of motivation or enthusiasm or by passivity	Ongoing direct observation. Specific feedback on expectations on level of work readiness and areas where they should be working independently. Specific task allocation.
Inattention, unpredictable mood, impaired performance. Absences. Not answering phone when on call.	**Missing in action:** This is a critical event and should trigger inquiry into personal health, substance use disorder, relational distress.	Documentation. Early communication with program director. Formal meeting to assess the issue and confirm concerns. Referral to program resources for professional assistance.
Inappropriate conduct with a patient or staff, breaking patient confidentiality.	**Inappropriate conduct** and unprofessional behavior that violates professional codes of regulatory bodies.	Documentation. Early communication with program director. Formal meeting with the learner to assess the allegation. Referral to program resources for professional assistance.
Difficulty leaving a shift or spending excess hours in clinical settings or completing charting or dictation.	**Insecurity about role:** Anxiety regarding clinical expectations, assessment or difficulty with prioritization	Ongoing direct observation. Specific feedback review of expectations for this level of learner. Permission to leave a shift without negative consequences. Promotion of self-care.
Learner spending excessive time in a consultation, completing charting or working after hours to complete clinical or administrative work	**Disorganisation,** inefficient use of time	Ongoing direct observation. Specific feedback on time management and improved strategies for efficiency. Put in the context of the level of the learner: Only incompetent if they are not at level of expected for their level of training and not improving with feedback. May also be a medical knowledge issue: If learner is not improving feedback then involving program resources for more in-depth look for possible learning issues may be necessary.
Learner withdrawn, fearful, tearful or under performing or makes complaint again a clinical preceptor	**Intimidation of learner** by clinical preceptor or inappropriate supervisor conduct	Program Director investigation and referral to program resources for learner and clinical preceptor
Learner falsifying clinical history or examination findings or clinical records. Manipulative, avoids work, rude or unable to follow directions. Negligent in patient care.	**Negligence:** Learner unable to be trusted, fraudulent conduct	Ongoing direct observation. Documentation. Early communication with program director. Formal meeting with the learner to assess the allegation. Referral to program resources for professional assistance. Specific feedback on expectations and supervised learner contact with patients in clinical settings

Failure to accept constructive criticism. Learner challenges preceptor clinical assessment, clinical reasoning, diagnosis and/or management consistently or continuously.	**Unreceptive to feedback:** Disrespectful to Program or Preceptor, Hostile or irreconcilably unteachable	Ongoing direct observation. Documentation. Early communication with program director. Formal meeting with the learner to assess the allegation. Referral to program resources for professional assistance. Formal discussion and curiosity about learners concerns with preceptors level of knowledge and performance.

These observations and coaching strategies could be used as a discussion or faculty development tool within your LIC.

Studies demonstrate that disciplinary action in practicing physicians by medical boards is strongly associated with unprofessional behavior in medical school (6). Professionalism can and must be taught and modeled (6). There is an expectation that as preceptors and medical school training programs we first observe and then assist our learners in difficulty.

The advantage of an LIC is ultimately direct observation of our learners over time and the ability to identify and provide strategies for improvement of learner difficulties. Well delivered feedback can improve a learner's skills in clinical and non-clinical areas. Timely detailed feedback regarding observations of the learner, in a conducive environment, by a non-judgmental mentor, with focused discussion is considered most likely to narrow gaps between actual and desired performance in a learner (5). It is noted that feedback should address behaviors that can be changed.

Learner difficulties in this article intentionally do not include the medical knowledge and clinical reasoning difficulties that learners can experience and readers are encouraged to refer to other sources for the diagnosis and management of medical knowledge and clinical reasoning difficulties.

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