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Remediation for struggling learners: putting an end to ‘more of the same’

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Two papers in this issue discuss the challenges posed by struggling learners. We would like to highlight a few of the key issues not only for clinical teachers, but also for those who seek to help them through faculty development.

Cleland and colleagues provide a useful state-of-the-knowledge on the conceptual and methodological bases of remedial interventions in medical education. One of their key findings is that there is a lack of theoretical foundation to many remedial interventions: more often than not, interventions amount to providing ‘more of the same’ to learners in difficulty. This resonates well with our experience. In a study of clinical teachers involved in the residency programme in the Department of Family and Emergency Medicine at the University of Montreal, we found that clinical teachers identified residents in difficulty easily enough, but their evaluations were intuitive and global. They felt unsure about what to do when residents had clinical reasoning difficulties and, as a result, significant time elapsed before any remedial actions were taken. When they were, interventions generally focused on organisational aspects of residency, such as reducing struggling residents’ clinical workload, rather than on tailoring remediation according to a specific diagnosis of the root cause of the difficulty. This pattern is likely to be attributable, at least in part, to supervisors’ difficulties in using a structured process, framed by appropriate theory, to generate a specific educational diagnosis of learners’ difficulties. These findings further illustrate Hesketh et al.’s model of excellence in clinical teaching: excellent clinical teachers need an appropriate approach to the tasks they perform.

In response to these findings, the Department of Family and Emergency Medicine at the University of Montreal developed a multidimensional strategy to support clinical teachers in remediating residents. This strategy consists of four prongs: implementing institutional procedures with regard to remediation plans and follow-up; introducing clinical teachers to conceptual frameworks and empirical findings from the literature through accessible and targeted papers; developing a guide to the diagnosis and remediation of different types of clinical reasoning difficulty, and providing teacher-centred faculty development. Altogether these strands amount to no less than a cultural and organisational change, which should help clinical teachers to act effectively, based on well-grounded educational scripts, with a strong sense of ‘being clinical educators’, which ultimately should improve outcomes for learners.

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We have found our strategy to be successful. In many cases, residents do improve significantly once a structured remediation plan has been put in place. These experiences have led us to concur with Cleland et al.’s assertion, based on control value theory, that early identification and remediation is key to avoid underperforming undergraduates becoming underperforming doctors by ending the repeated cycle of poor performance, negative feedback, low self-efficacy beliefs and reduced motivation. Although external feedback may be particularly important, from a self-regulated learning perspective, for underperforming learners who tend to also be poor self-assessors, consistently negative feedback may be counterproductive. Indeed, from a control value perspective, such feedback can induce negative emotions, which, in turn, can trigger maladaptive learning strategies such as the avoidance of challenging situations. This is evidenced in the paper by Mitchell and colleagues, which reports that junior doctors in difficulty, who have had some autonomy in selecting which workplace-based assessments to submit
Early identification and remediation are key to helping underperforming undergraduate students. 

![Early identification and remediation are key to helping underperforming undergraduate students.](image)

That said, as much as educators generally desire to help their trainees succeed, in cases where residents do not improve after remediation, the intervention may still be considered successful if it helps expedite the process of excluding them from the programme. Allowing underperforming learners to remain in the curriculum for prolonged periods risks wearing down their clinical teachers. Struggling learners can lead similarly struggling teachers, who may themselves end up feeling helpless as a result of the repeated failures of their interventions. In fact, control value theory would suggest that such negative and deactivating emotions might result in poor practice. This leads us to propose an alternative or supplementary hypothesis as to why the junior doctors in Mitchell et al.’s study turned to nurses or other junior doctors for assessment: perhaps more senior doctor teachers were less available because they avoided having to deal with struggling doctors (even non-deliberately) and focused on well performing students or on the execution of more satisfying responsibilities, such as the delivery of patient care. By empowering clinical teachers to attempt well-designed remediation and to document their interventions and their results, the culture change for which we advocate can lead to feelings of control and satisfaction in clinical teacher. Even when this role leads to learner dismissal, clinical teachers can find solace in the knowledge that they did everything in their power to help the learner.

Dealing with learners in difficulty is challenging. However, we believe that faculty development centred on the needs of clinical teachers is necessary as it has the potential to lead to both better learner-centred remediation and the empowerment of learners, as well as clinical teachers.

**REFERENCES**


