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“Failure to Assign Failing Grades”: Issues with Grading the Unsafe Student

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“Failure to Assign Failing Grades”: Issues with Grading the Unsafe Student*

Florence Luhanga, Olive J. Yonge, and Florence Myrick

Abstract

In a grounded theory study examining the process of precepting an unsafe student, it was found that preceptors assigned passing grades to students who in fact should not have passed. Although preceptors perceived their role as gatekeepers for the profession, by not assigning failing grades to students who should not have passed a course, essentially they were abdicating their responsibility. Indeed, the simple act of assuming responsibility for precepting a student implies professional as well as pedagogical accountability.

KEYWORDS: preceptorship, grading, unsafe student, nursing education

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Although for some students the preceptorship experience serves as facilitation into professional practice, there are a number of students who require closer supervision owing to a skills deficit (Yonge, Krahn, Trojan, Reid, & Haase, 2002a). While preceptorship programs are increasingly popular, little is known about the process of precepting students with an unsafe level of practice and even less is known as to how preceptors manage such students (Scanlan, Care & Gessler, 2001).

The term “unsafe student” is used to refer to students whose level of clinical practice is questionable regarding safety, and who exhibit marked deficits in knowledge and psychomotor skills, motivation, or interpersonal skills (Hrobsky & Kersbergen, 2002; Scanlan et al., 2001). Unsafe practice in a clinical setting may be described as any act by the student that is harmful or potentially detrimental to the client, self, or other health personnel. In this study, researchers sought to determine how preceptors teach and manage unsafe students. One of the themes that emerged from the data was the dilemma of evaluating and finally grading an unsafe student.

LITERATURE REVIEW

A recurrent issue in the literature within the context of the preceptorship experience is that preceptors often have little or no experience with regard to the role of evaluation (Hrobsky & Kersbergen, 2002; Scanlan et al., 2001; Seldomridge & Walsh, 2006; Yonge, Krahn & Trojan, 1997a). Yet, preceptors are expected to provide faculty with important feedback as to whether a student’s practice meets the standards delineated by the school or profession. In a study by Yonge et al. (1997a) a discrepancy was found to exist between how little preceptors are prepared for the evaluation role and yet how frequently they are expected to perform this role.

Many examples of reluctance to award a failing grade and of “giving the benefit of the doubt” to marginal or unsafe students are well documented in the nursing and professional literature (Boley & Whitney, 2003; Cowburn, Nelson & Williams, 2000; Dudek, Marks & Regehr, 2005; Duffy, 2004; Hawe, 2003; Scanlan et al. 2001). Recently, in the United Kingdom (UK), Duffy (2004) found that preceptors were passing students even when they had doubts about their performance. The study revealed that preceptors find it difficult to fail students and are predisposed to allow the personal problems of failing students to influence their judgments. Reasons identified as to why students passed when their performance failed to meet the minimum standard included: reticence on the part of the preceptors to identify or resolve the student problems early enough in the

clinical placement; the threat of the university's appeals system; and lack of preceptor adherence to appropriate procedures when assigning a failing grade.

Duffy (2004) however, explains that preceptors, need to be prepared to assign failing and passing grades. She further recommends that they need to communicate concerns about a student as early as possible, particularly in writing, to faculty members. Failure to do so often means no action can be taken. Preceptors are further reminded of their professional responsibility as *gatekeepers to the profession*, with the purpose being to prevent borderline students who engage in unsafe practice from becoming registered practitioners, thereby protecting the public from incompetent practitioners.

In a study by Scanlan et al. (2001), several issues were identified as being inherent in beliefs and practices of nursing faculty that also contribute to difficulties in dealing with students who engage in unsafe practice. First, there is a prevailing belief among clinical teachers that students need time to learn and that failure early in the program does not allow the student enough time to succeed. Second, being uncertain about their role, especially in relation to evaluation, novice clinical teachers lack conviction in their evaluative decisions (Scanlan et al.). Third, nursing is perceived as a caring profession and as such, failing a student in clinical practice may be perceived by some as reflective of uncaring practice (Scanlan et al.).

In Canada, Dudek et al. (2005) conducted a qualitative study among physicians (clinical supervisors) in which they explored factors that affect their willingness to report students' poor clinical performance. Areas of the evaluation process that were identified as barriers by the supervisors included: lack of documentation; lack of knowledge as to what to specifically document; anticipation of an appeal; and lack of remediation options. Many preceptors had been threatened with legal action; however, the time involved in the appeal process was threatening enough to consider passing an unsafe student. Finally, some participants who had already undergone an appeal felt there was lack of support from the faculty when an evaluation was challenged. Similarly, Boley and Whitney (2003) explained that in the current litigious society, some nursing faculty members fear being sued and are thus even more reluctant to fail a student based solely on poor clinical performance.

The prevailing discourse in the nursing literature indicates that it is the responsibility of the faculty member to recognize unsafe nursing practice and assign a failing grade if one is warranted (Boley & Whitney, 2003). There is little research, however, to guide preceptors in difficult or complex learning situations

when nursing students are failing to meet clinical objectives or displaying unsafe practice (Hrobsky & Kersbergen, 2002).

METHODOLOGY

Design

To date, there is little literature regarding the process of precepting students with unsafe practices. A grounded theory method was thus chosen to carry out this study (Glaser & Strauss, 1967; Strauss & Corbin, 1998). The aim of the grounded theory approach is to develop a substantive theory about common social-psychological patterns.

The foundations of grounded theory emanate from a theory of symbolic interactionism in which the processes of interaction between people's social roles and behaviours are explored (McCann & Clark, 2003a). Meanings are created through experience, and although these experiences are unique to each individual, those sharing common circumstances, such as preceptors, experience common perceptions and thoughts, and display common behaviours, the process of which is the essence of grounded theory (McCann & Clark).

Participants

Twenty-two nurse preceptors involved in a final-year clinical practicum provided the sample for the study. The majority were female and two were males. The participants' age ranged from 26.5 to 62 years, although three quarters of the preceptors ranged between the ages 40 and 60. Almost two thirds of the preceptors in this study had diploma level of preparation, while slightly more than one third was prepared at the baccalaureate level. Participants indicated that they had from 0 to 16 years of precepting experience with a mean of 5.9 years. Preceptors had precepted from 1 to 20 students during their careers with the average number of students being 6. Seven indicated they had never received any preceptor training with 2 indicating their training had been years ago. The main criteria for inclusion were previous knowledge and experiences dealing with students engaging in unsafe practices.

As the data emerged, however, a select number of preceptors with no direct experience of such students were also asked to participate. This process enabled the researcher to search for 'negative cases'. Theoretical sampling continued until theoretical saturation was achieved. Saturation in grounded theory occurs "when no new data emerge relevant to particular categories and

subcategories, categories have conceptual density, and all variations in categories can be explained” (McCann & Clark, 2003a, p. 11).

Data Collection

Permission to conduct the study was sought in writing from the Associate Dean of the undergraduate nursing program and ethical approval was received from the Ethics Review Committee. A combination of data-collection methods is characteristic of grounded theory (Charmaz, 2000). Data were collected mainly through one-to-one semi-structured interviews with individual preceptors that lasted between 20 and 50 minutes. The study was conducted in selected acute care practice settings. Interviews with participants, initially accessed through the respective hospitals, were conducted at a mutually agreed upon place and time. A review of official documents such as guidelines for preceptorship was also conducted to supplement data whenever necessary. It was assumed that multiple approaches to data collection would provide richer data than a single approach. The interviews evolved, in content, based on responses from participants. The questions in the interview guide were obtained and compiled from the literature.

Study Rigor

The rigor of the study was ensured through the following mechanisms. The researcher had participants validate study findings through member checks and member validation as proposed by Sandelowski (1986) to ensure credibility. Credibility was achieved by the researcher engaging with participants over time and by developing rapport, establishing trust, and working collaboratively with them. Fittingness was enhanced by collection of data from different acute care settings. The researcher ensured there was a comprehensive audit trail for future use by others to ensure confirmability.

Data Analysis

Data were analyzed by the researcher using constant comparative analysis as described by Glaser (1978). The main goal of data analysis in a grounded theory approach is to discover a core variable which illuminates and explicates the main theme of the preceptor’s experience (Glaser, 1978; Streubert & Carpenter, 1999). Data analysis began simultaneously with data collection and was achieved through the process of coding. Coding occurred at three levels: open coding, theoretical coding, and selective coding. Open coding is the process of ‘fracturing’ or breaking down the data into discrete parts to identify and name relevant categories (McCann & Clark, 2003a). Theoretical coding is a process in

which the ordering of the data and the interrelation of the substantive categories occurs. During selective coding, the researcher moved from data analysis to concept and theory development. This was accomplished through the process of data reduction, by filtering information relevant to the topic, discarding extraneous information, and selective sampling. During this stage, the core category that tied all other categories in the theory together was identified and related to other categories (Glaser, 1978). The data analysis revealed a multifaceted process which was labeled “promoting student learning and preserving patient safety” as the core variable or main process involved in precepting a student with unsafe practice. Five major categories were revealed: (1) hallmarks of unsafe practices, (2) factors contributing to unsafe practice, (3) preceptors’ perceptions and feelings, (4) grading issues, and (5) strategies for managing unsafe practice. The category “grading issues” is the focus of this article.

FINDINGS

One of the guiding interview questions was, “In your experience, do students sometimes pass clinical placements without having gained sufficient competence?” The majority of the preceptors interviewed acknowledged that indeed sometimes students pass their clinical practicum without having gained sufficient clinical experience. One preceptor illustrated:

In my very quick experience with [grad nurses on the unit]... you can tell that they lack a number of skills. They lack foresight to understand... the lack of their knowledge leads to problems with their patients... but their skills are just not at par.

One preceptor gave an example of a BScN graduate who had completed her training without having given an injection. From the data about “grading issues” a number of subcategories emerged. These were: 1) reasons for presenting as an unsafe student, 2) reasons for failing to fail borderline or unsafe students, and 3) the role of the preceptor as a ‘gatekeeper to the profession.’

Reasons for Presenting as an Unsafe Student

Participants confirmed that some students were not acquiring sufficient practical skills in the university program. Many criticized the problem-based learning (PBL) approach currently used in the university program, as they felt it did not provide students with adequate skills or basic knowledge required of a beginning competent practitioner. One preceptor expressed her opinion that “the

university teaches students how to think, but not what to think.” Some preceptors explained that most third year students give more credence to what they learned during summer months while working as Employed Nursing Students (UNEs), in comparison to what they learned during all of their previous clinical courses at the university. While preceptors appreciated the theoretical and broad research-based knowledge provided to students through their university program, they also believed that, because nursing is a practical discipline, students need to be given sufficient time for clinical experience to acquire the skills required of a competent graduate nurse.

Another striking concern expressed by preceptors alluded to the fact that faculty sometimes assigning passing grades even when preceptors had raised concerns regarding students’ poor clinical performance. This was proposed as an explanation for the skill deficits often presenting in the final practicum as a result of passing earlier clinical courses. As one preceptor related: “I know of an incident, we were all wondering, ‘oh she is still working here’.” It seems the instructor just assigned a passing grade anyway and no explanation was given as to why the student passed.

Reasons for Failure to Fail Borderline or Unsafe Students

During the interview, preceptors were asked why it was so difficult to assign failing grades to students in the clinical practice component. The majority of preceptors acknowledged assigning a failing grade was one of the most challenging responsibilities.

It’s a really hard decision to make, sometimes as a preceptor it’s one you don’t want to make. You don’t want them to be disappointed in you. You don’t want them to have to repeat it, and that’s probably one of the hardest things to do as a preceptor, to say you are not doing good enough.

Participants identified several reasons why students passed when their performance was unsafe. These themes were: 1) lack of experience as a preceptor, 2) reluctance to cause students to incur personal cost, 3) personal feelings of guilt or shame, 4) complacency or reluctance to assume the extra workload, 5) lack of appropriate evaluation tools and time to evaluate sufficiently, and 6) pressure of the perceived nursing shortage for preceptors to create graduates.

Some preceptors acknowledged they were reluctant to assign failing grades to students because of their lack of experience or confidence in their

preceptor role. As one commented, “I guess it is my lack of experience of being a preceptor. I didn’t really know how to do it in a nice way, probably, so I let it go.”

Preceptors acknowledged passing students because they did not want to jeopardize the students’ future, especially when they were so close to graduating, and because of the perceived significant personal cost to the student. Some preceptors were reluctant to assign failing grades students because of the amount of money involved in the university education.

Other preceptors reported that because they are members of a caring profession they are reluctant to assign failing grades. Some fear the consequence of failure, because they interpret student failure as their own failure or incompetence. Some preceptors suggested their reluctance was due to fear of being labeled as a ‘bad person’ by other staff or students. Some preceptors also reflected that students occasionally received passing grades because of the close student preceptor relationship or because the preceptor felt the student was a ‘nice’ person.

Some preceptors suggested that students are given the *benefit of the doubt* because of complacency or laziness on the part of the preceptor, while others noted that preceptors pass students simply to get them out of their way, thus passing on the student deficits to the next person to deal with. One preceptor admitted she would not want to assign a failing grade because of the extra workload involved. Yet, other preceptors attributed lack of failing grades to inadequate concrete evidence or documentation to validate their claims of student risk and, as such, found it difficult to assign a failing grade.

Other preceptors found it difficult to recommend failing grades to students when they did not have enough time to observe the student in clinical practice. One participant suggested that some preceptors do not deal with the students’ problems early enough during the clinical placement, explaining that failure to do so would imply that no action could be taken, and, as such, the student passed. Another preceptor commented that the clinical evaluation tool did not have many objectives in relation to the affective domain. As such, preceptors found it difficult to assign a failing grade based on non-cognitive skills, such as poor attitude.

Lastly, two preceptors believed students passed because of the current nursing shortage. As revealed in the following comment, “I think it’s because we need nurses so badly. So quickly they are rushed through.”

Role of the Preceptor as a 'Gatekeeper to the Profession'

Interestingly, while preceptors indicated their reluctance to recommend failing grades to borderline students, when asked if they would want to work with these students upon graduation, most indicated they would not. For instance, one preceptor had recommended that upon graduation her student should not work on the unit, because the student was not suitable or competent enough for the unit at the time. On a more positive note, while preceptors acknowledged the challenges with which they are faced when making final comments or deciding either to recommend a failing or passing grade, they also recognized and accepted their role as *gatekeepers* to the profession. As one preceptor acknowledged, "But reality is also in my head that we need to be careful because ... the nurses out there ... functioning below par influence the public impression about nursing in general."

Another related issue raised by two preceptors was the fact that instructors also sometimes assign final student grades before they have seen the preceptor's evaluative comments. They felt this undermined their role as evaluator and that the grade did not accurately reflect student performance.

DISCUSSION

The majority of the preceptors in this study acknowledged that some students pass their clinical practicum without having gained sufficient clinical experience. This occurrence has a number of serious implications for the profession as a whole. It suggests that the self-regulating factor is not functioning as it should be, thereby ultimately affecting public perception and confidence in the nursing profession.

Assigning a failing grade to a student is perceived as an act of bravery by preceptors, one that is not taken lightly, and one that only occurs in situations where student performance is seen to be very substandard. As such, when their decision to recommend or assign a failing grade is not taken into consideration, preceptors may feel belittled. Unless such issues are carefully resolved, preceptors may feel betrayed by the educational system and withdraw altogether from precepting students. It is encouraging, however, to note that some preceptors realize the important role they possess as gatekeepers to the profession. Nursing faculty must ensure the role of the preceptor as an evaluator is emphasized and supported so that they may fulfill this important function on behalf of the educational institution and ultimately the profession and the public.

One of the concerns in this study was the reluctance of preceptors to assign failing grades for poor performance. This reluctance, however, has been reported in various professions including social work, nursing, medicine, and education (Boley & Whitney, 2003; Cowburn, et al., 2000; Dudek et al., 2005; Duffy, 2004; Hawe, 2003; Scanlan et al., 2001). Several reasons were identified by preceptors in this study as to why students passed when their performance was less than acceptable. The reluctance to assign a failing grade due to lack of experience or confidence in the preceptor role has been expressed by clinical teachers and preceptors in previous studies (Dudek et al.; Scanlan et al.). Scanlan et al. suggest novice clinical teachers have difficulty evaluating students due to lack of preparation for their evaluation role. This has implications for preceptor preparation and staff development, particularly in the realm of evaluation.

Some preceptors chose to assign a passing grade because they did not want to jeopardize the student's future due to the significant personal cost to the student (Dudek et al., 2005; Duffy, 2004; Hawe, 2003). While fear of legal implications has been highlighted in the literature as one of the factors contributing to preceptor reluctance to assign a failing grade to a student (Boley & Whitney, 2003; Dudek et al.; Duffy), for preceptors in this study, it was not an issue. This may be partly because, unlike the UK (Duffy, 2004) and other professional programs, in nursing education, faculty retain the ultimate responsibility for evaluation and grading a student's clinical performance (Ferguson & Calder, 1993).

Nursing was perceived as a caring profession, thus, failing a student in clinical practice was regarded as an uncaring practice (Duffy, 2004; Scanlan et al., 2001). In some instances, preceptors interpreted the awarding of a failing grade as reflective of their own personal failure or incompetence and experienced feelings of guilt, shame, or inadequacy (Anders, 2001; Duffy, 2004; Hawe, 2003; Scanlan et al.). Likewise, one preceptor in this study admitted she would not want to fail the student because of the extra workload involved in such a process (Dudek et al., 2005; Duffy).

Furthermore, some preceptors indicated that sometimes students pass because of the close student preceptor relationship (Anders, 2001). While preceptors are encouraged to develop a good relationship with students, it is important that they maintain clear professional boundaries with those students to ensure their capacity for providing objective and effective feedback.

Others in this study suggested preceptors sometimes assign passing grades just "get them out of their way," leaving the problems for the next person to

resolve (Duffy, 2004). For instance, preceptors who do not like confrontation may find it easier to assign a passing than a failing mark. These findings suggest that the concept of conflict resolution requires special attention in preceptorship workshops as most nurse preceptors prefer to avoid conflict and confrontation (Speers, Strezywski & Ziolkowski, 2004).

Reluctance to assign a failing grade based on non-cognitive or affective skills has been well documented in the nursing literature (Duffy, 2004). In Hayes, Huber, Rogers, and Sanders' (1999) study, non-cognitive behaviors accounted for 56.7% of the behaviours of concern, but only 35% of these behaviours resulted in a negative outcome for the student. Likewise, some preceptors in this study expressed difficulties with assigning failing grades based on poor attitude or unprofessional behaviour, often related to the inappropriateness of the evaluation tool. This concern may require further exploration so learning outcomes related to professional behaviour and attitude can be given prominence within the clinical evaluation tools.

Preceptors reported that students had to demonstrate consistently poor performance before they would be assigned a failing grade (Duffy, 2004). Failure to communicate concerns about a student to faculty early enough in the placement means no action can be taken, and as such, students pass (Duffy). Moreover, leaving it until late in the rotation meant the student may not be afforded sufficient time to improve. Some preceptors confessed to allowing weak students to pass with a hope the student would acquire the necessary skills in future placements or in practice. Such an approach, however, has potentially negative consequences for patients, clients, students and future preceptors (Duffy; Scanlan et al., 2001).

Some preceptors in this study stated they find it difficult to assign failing grades owing to insufficient time to observe students in practice (Duffy, 2004; Dolan, 2003). For an evaluation to be valid and effective, it has to be based on accurate and ongoing assessment, and derived from the preceptor's personal observations of the student. Similarly, participants in a study by Dudek et al. (2005) acknowledged that in most cases they did not keep records of student performance. Consequently, when challenged, they could not produce evidence to support their decision because they could not recall specific incidents.

Lastly, two preceptors believed students passed because of the current nursing shortage. This view has not been previously raised in the nursing literature but is an issue that requires further exploration.

Preceptors also expressed the concern that students sometimes pass even when concerns have been raised about their clinical performance. However, while most preceptors believed their evaluative comments were taken into consideration by faculty when the final grade was determined, they questioned if students think otherwise. This may have implications for whether students will view their preceptorship experience seriously.

Indeed, the simple act of assuming responsibility for precepting a student implies accountability not only professionally but also pedagogically; and accountability entails responsibility. When preceptors accept responsibility for precepting nursing students, in addition to their professional role, they accept some educational responsibilities including the evaluation of the student's clinical performance (Ferguson & Calder 1993; Wallace, 2003). Consequently, it is crucial that nurses recognize the important role they assume in this process, as well as the inherent challenges.

Nursing faculty and preceptors, have an academic, legal, and ethical responsibility to ensure that nursing students are sufficiently competent when they graduate so as to protect the public from unsafe nursing practice (Billings & Halstead, 2005; Boley & Whitney, 2003; Smith, McKoy & Richardson, 2003). Consequently, preceptors who do not assign a failing grade to borderline or unsafe students are doing harm not only to the student but also to the profession. Because the profession is itself accountable to society, by inference the preceptors as evaluators are also morally and ethically accountable to the profession (Harding & Greig, 1994).

In the preceptorship model, it is assumed that preceptors can teach and evaluate students (Coates & Gormley, 1997). Some of the preceptors in this study, however, like others in previous studies, reported that students who should not have passed may have passed owing to their own lack of experience and confidence in the evaluation role. Ferguson and Calder (1993) cautioned that although preceptors possess clinical expertise, they may not have skills required for teaching, supervising, and providing evaluative feedback. Harding and Greig (1994) stressed the dilemma of practitioners' possessing insufficient experience and preparation to assume accountability for teaching, supervision, and learner assessment. Clinical teaching and supervision are professional skills that require adequate preparation. It cannot, therefore, be assumed that practitioners can automatically function as preceptors with such skills (Coates & Gormley, 1997; Kaviani & Stillwell, 2000). While the preceptor's clinical expertise and knowledge are invariably fundamental to a successful preceptorship experience,

other qualifications of the clinical preceptor such as previous teaching experience are also crucial.

An effective preceptor must possess an appropriate teaching background and have an understanding of underlying pedagogical theory (Karuhije, 1986; Myrick & Barrett, 1994). According to DeYoung (2003), preceptors must have knowledge of what to teach, be familiar with the best methods used to teach, understand how students learn, and possess the necessary skills with which to appropriately evaluate student performance. These findings highlight the need for preceptors to be adequately prepared and supported so that they may be truly accountable for the teaching and evaluation of students.

CONCLUSION

The tendency of preceptors in this study to assign passing grades to students when failing was warranted indicates that ongoing professional development and support is clearly needed (Hawe, 2003). As well, it is important for preceptors to realize, when they accept the responsibility for precepting nursing students, they concomitantly accept educational responsibilities that include evaluation of student performance (Ferguson & Calder 1993). It is important, therefore, that preceptors recognize the critical role they assume in this process, and be familiar with the potential difficulties they may encounter when they assume such a role. While the issue of “failure to fail” a borderline student is not a new problem, preceptors need to acknowledge and accept that some students will fail (Duffy, 2004) especially if a high standard of professionalism is to be fostered. It is reassuring that while preceptors in this study acknowledged the challenges with which they were faced when making final decisions on the success of students’ clinical performance, they also recognized and willingly and graciously accepted their role as gatekeepers for the profession.

RECOMMENDATIONS

This study raised several issues that warrant further investigation. As indicated, there continues to be limited research related to the management of unsatisfactory or failing students in preceptorship relationships. The participants in this study were preceptors from acute care settings who were associated with one undergraduate nursing program. Replication of this study both nationally and internationally is required to further explore the issues of professional and pedagogical accountability raised by findings of this study. To enhance our understanding of the “unsafe” student within a preceptorship relationship,

additional research is required from the perspective of nursing faculty and students.

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