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The Unwillingness to Award an Unsatisfactory Grade when Assessing the Performance of those Intending to become Health or Social Care Professionals, Sometimes Described as "Failure to Fail"

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Abstract

Those marking examinations testing factual knowledge appear to have little difficulty in awarding a fail grade when a health or social care student's performance was below a minimum acceptable standard. Yet when assessing performance and behaviour on placements or assessments of professional practice, there is a widespread reluctance when faced with unsatisfactory performance, to award fail grades. The phenomenon affects students of all health and social care professions, and those of other professions such as teaching or accountancy. The result is that seriously unsatisfactory students may be allowed to graduate and enter a profession, ill-equipped for the tasks they face. This paper reviews the numerous obstacles to awarding fail grades, a phenomenon often described as "failure to fail". One factor, not previously reported, is dishonesty involving the process of assessing practical skills. Educators need to appreciate that they have a gatekeeping role, and a responsibility to avoid unsuitable and possibly unsafe students from entering a profession until they are ready and able to perform the tasks necessary to practice the profession. Allowing unsuitable students to proceed does them no favours, is likely to be setting them up for serious professional difficulties after entering professional practice, and could endanger patients, clients or service users.

Keywords: Failure to fail; Assessment of professional practice; Professional suitability

Introduction

Educators have an academic and professional responsibility to teach, supervise and evaluate the performance of health and social care students to ensure that they are competent to perform clinical tasks. Part of that responsibility includes assigning fail grades to students who have not demonstrated the required level of competence, whether during a placement or during a formal assessment during or at the end of an educational programme. However there is evidence in the literature that many educators find it difficult to identify, and make decisions about, students who display unsatisfactory or incompetent performance. The problem affects medical education [1-19], nursing education [20-41], social work education [42-49], and it has been seen in other education programmes such as occupational therapy, physiotherapy and dentistry [50-57]. The term "failure to fail" has been used to describe clinical supervisors or assessors who do not fail students or trainees even though they have judged their performance to be unsatisfactory. Another term used is the "mum effect", a reluctance to report unfavourable assessment [16-18]. This paper reviews the causes and the professional implications of failure to fail, and highlights the need for educators to pay greater attention to this widespread problem.

Educators as gatekeepers

As Hunt et al. [34] explained "Irrespective of the profession or country concerned, there is an agreement that those who assess professional practice of those in training are the gatekeepers of their profession. They and they alone determine whether the practice they have observed is or is not of the required standard. If they do not fulfil this role then it is possible for under-performing students to enter a professional register with potentially risky consequences for the client group concerned". As gatekeepers to their respective professions, educators have a duty to ensure that only students with the appropriate knowledge, skills and values to serve patients, clients and service users are allowed to graduate from professional education programmes and be admitted to a programme, thereby protecting society from incompetent or unsafe practitioners [37].

As has been pointed out [34], achieving qualification as a nurse and being permitted to enter the nursing profession "indicates to the profession, to patients and to employers that an individual has developed a sound foundation from which to begin practising and on which further, more detailed and specialised development can be built. The practical assessment of students, therefore, serves a crucial purpose as one of the principal means through which the professions

regulate entry……. Assessment should provide a means of excluding those who are unsuitable before they reach registration. If all students pass then professional standards cannot be upheld and there seems little point in having assessments at all" [58].

Yet it has been known for many years that assessors of practice are reluctant to fail students in assessment, generating doubts about the fitness to practice of some health professionals. This is a worldwide matter of concern to all practice-based professionals as diverse as nursing, medicine, teaching and accountancy [34].

Failure to fail and its many possible causes

It is possible to distil a number of possible factors to help one understand why failure to fail remains a widespread problem affecting the training of students of many health and other professions.

- Ratings are known to have a positive bias, which has been described as "generosity error", and often fail to document serious deficits [3,57]. "Clinical ratings are especially notorious for failing to document students' shortcomings. The episodic, fragmented, and relatively small amount of contact that clinical faculty have with students often leaves then reluctant to make ratings that would call attention to a student's performance deficits. They are concerned that, with such limited contact, they should not assign a rating that would have such a severe impact on a student's future. The student's problem may go unaddressed if no faculty member is willing to go on record stating that the student has severe deficiencies" [3].
- One reason for the failure to reflect students' shortcomings in their rating is the current climate in which there is limited time for clinician supervisors to devote to teaching students. "There are major disincentives for faculty to rate students negatively, for they are then called upon to spend precious time discussing the ratings with the course director, student, deans, lawyers etc. Even ratings just slightly below the maximum frequently prompt students to vigorously and tenaciously argue their cases before their raters, fearing as they do that any rating but the best will keep them from getting the residencies of their choice. With the stakes so high for students, the pressure on faculty to give only positive ratings is intense" [3].
- It has been said that evaluation of students in clinical practice has had a "long and tortured history" [59]. The task of assessing healthcare students on clinical placements is inherently difficult because it requires it requires the direct observation of students engaged in clinical practice in unpredictable clinical environments [60]. Clinical evaluation and work based assessment is complicated by the fact that teachers fulfil multiple and seemingly incompatible roles (clinical teacher, mentor, participant-observer and judge/gatekeeper). Observation and interpretation of clinical performance are largely subjective. Efforts to address the challenge of subjectivity and inconsistency in clinical evaluation have been directed to objectifying clinical practice and standardising assessment procedures, such as (in the UK) the use of the objective structured clinical examination (OSCE) [61]. Although there are many difficulties associated with assessment of clinical students [62,63] the boundary between competence and incompetence is critical, and is part of the process of protecting the public from unsafe, incompetent and unscrupulous professionals [53].
- One relatively recent study of nursing education at 27 universities in the UK [34] showed that there was a large difference between theoretical and practical assessments. Taking data from all three academic years, 4% of students failed theoretical assessments and were withdrawn from programmes as a result. In contrast, only 0.8% of students were withdrawn from courses based on failure of a practical assessment, demonstrating a 5:1 ratio of fails in theoretical assessment to fails in practical assessment. This supports the view that assessors avoid failing underperforming students in practical assessments. Twenty five percent of universities studied did not fail and withdraw any students based on practical assessments during the 3 year programme. The results supported the views of many that assessors particularly avoid failing underperforming students in practical assessments.
- Similarly, in one study of 19 medical schools in the USA, two stated that they did not have any system for terminating the studies or dismissing a student [64]. In a study of 10 medical schools in the USA, unwillingness to record negative evaluations, failure to act on negative evaluations and reversal or dilution of negative evaluations were common findings. None of the medical schools studied was exempt from these problems [1]. Similar comments apply to the education of social workers, and in a national survey of 81 social work education providers in the USA, it was found that 67% had no policy that would enable the termination of students for nonacademic reasons, in other words problems with behavioural attributes [65].
- Health and social care students are generally compassionate individuals who enter their profession to help people, and when they become involved educators apply their caring qualities to help and support students. When students struggle, the natural inclination is to support and invest in them, to help and foster their career. There can be a tendency to treat students as patients, losing sight of responsibilities to the education provider or to the public.
- There is a repulsion for harming and a strong desire to help students, and a widespread recognition of the difficulties involved in failing students. One paper wrote rather graphically "Teachers who find this difficult to accept as anything but an excuse for unprofessional cowardice may like to ponder on the difficulties of telling a colleague about a problem with personal freshness!" [21]. Another paper made reference to "advocating for vulnerable individuals and valuing relationships instead of advocating for normative standards" [49].
- Dealing with a problem student can be further complicated if the student has a disability or a mental health problem [66], which can encourage an educator to treat the student as a patient and lose sight of the need to ensure patients are protected.
- Concern about students' financial issues may be a factor [15]. There may be special sympathy because a student is in debt, and concern that paying off that debt will be much harder if the student is prevented from graduating and entering clinical practice.

- There is a taboo about using the word "failure" [53]. It is a word and a deed that is often avoided, replaced by various euphemisms such as "deferred success", "not yet competent", "non-attainment", and sometimes accompanied by permission for endless repeat attempts of an assessment. Teachers are reported to avoid using the 'f' word [67], such avoidance almost amounting to denial. As has been pointed out [53] these negative stereotypes disown the positive contribution of failing, whether to learning, for example through trial and error, or experiential learning, or as a catalyst for change. "There may be serious consequences when semantic avoidance leads to awarding a pass rather than fail grade in professional training" [53].
- Failing a student can have an adverse effect on a teacher, summed up by Turkett [20] "The student wants to succeed. The teacher wants the student to succeed. The student fails. Both feel like failures".
- Education providers may be penalised, either directly by loss of tuition fees or indirectly by the number of students who fail to complete the education programme, such failures possibly being regarded as a sign of a failure of an education provider to support its students;
- Failing a student creates conflicts, which are inevitably unsettling for both students and educators, described in one study as "a new horizon of moral courage" [35]. It has been suggested that one possible consequence of this conflict is avoidance, coupled with a feeling isolated and abandoned by their institution, sometimes acting as a deterrent to further involvement in educational activities [19].
- Lack of documentation can make it hard or even impossible to fail a student. It is a strange fact that health and social care professionals usually recognise the importance of keeping careful and detailed records of interactions with patients, clients or service users, but not uncommonly fail to maintain adequate records of the performance of their students. Decisions to fail and terminate the studies of a student require adequate documentation if the education provider is to be able to defend such decisions when challenged.
- There is a duty to provide clear warnings to students, setting out details of the inadequate performance, the change that needs to be seen, and the consequences of failure to improve [18,68].
- One reported deterrent to failing a student is a perceived lack of remediation options [64]. Another is a lack of confidence in the effectiveness of remediation for students with certain personality traits [10].
- The knowledge that decisions to halt a student's studies may not be supported, either by staff at the programme level or by staff higher up at a university level, with a real prospect that decisions are overturned on appeal, those dealing with these appeals being remote from professional work. Successful appeals tend to deter staff from acting when confronted by a seriously struggling student, if the perception is that intervention is pointless.
- One reported deterrent to failing students is a feeling of pointlessness because of the knowledge that dismissed students can (and often do) apply to the same educational programme run by another education provider. There are a number of variations of so-called "re-cycling" of failed students, including applying to study the same programme elsewhere, applying to study a different programme elsewhere, sometimes accompanied by attempts to conceal the record of failure by changing names and falsifying the date of birth. TJD has encountered a healthcare student who used 4 false names and 4 false dates of birth, the matter having come to light when a disaffected former partner reported the matter to the education provider.
- The threat, whether real or perceived, or possible legal action against a medical school that has terminated the studies of a student, can be a deterrent to failing a student [15]. Legal actions impose a considerable burden on staff involved with a student and can be very costly to defend. Whilst it is often said that education providers should be safe if due process has been followed [69-80], the experience in the UK at least is that a number of cases wholly lacking merit have nevertheless had to be defended by universities in the High Court, often at immense cost [81].
- There is a concern that failing students may have the effect of excluding students who are capable of growth and change, or as put by Lafrance et al [48] "can we justify excluding people who may be unready rather than unsuitable?". The counter argument is to have a system that protects the public from unsuitable professionals but which nevertheless gives them an opportunity to demonstrate change at a later date.

Dishonesty or lack of integrity as a cause of invalid assessments

The General Medical Council is the national medical regulator in the UK with a role in overseeing medical education. It mandates that all medical students trained in the UK have to be able to demonstrate proficiency in certain basic clinical skills such as measuring the blood pressure, taking blood, giving an injection, suturing a wound, breast examination, prescribing, obtaining consent from a patient, testing urine, or explaining and discussing a pregnancy test. Proficiency has to be assessed and certified by a suitably experienced doctor who has been deemed competent to carry out the procedures being assessed. There are at least two ways that dishonesty can be involved.

In one case, a qualified doctor approached a group of final year medical students and offered to complete skills assessments without actually observing or assessing the students performing the skills. The doctor then completed practical skills assessment forms for eight students, despite having not observed the students performing these skills, and falsely certified that the students had been observed. The completed assessment forms contained additional details such as for one assessment "Good communication skills! Made patient feel very comfortable", for another assessment "Well done!", and for a third assessment "Good technique, wound looks very good." All of these comments implied that the doctor was reporting on properly conducted and properly observed procedures. The background to the dishonesty appears to have been a culture where these skills assessments were not taken as seriously as they should have been, and the need to complete the necessary paperwork was seen by some staff as an unnecessary and irksome burden. The doctor was reported to the General Medical Council, which took disciplinary action.

One of the necessary components of these skills assessments is that they must be performed by independent members of staff who are not related to the student being assessed. However there have been occasions encountered in Manchester when medical students have persuaded their own medical relatives to complete and certify clinical skills assessments, the medical relative sometimes being an individual not deemed to be competent to carry out the procedure being assessed.

Discussion

The fundamental requirements are an ability to recognise that a student is failing, an availability of remediation programmes [82], and in the most serious cases an ability and a willingness to halt the studies of an unsuitable individual. The existence of multiple barriers as described in this paper explains why failure-to-fail is a continuing problem. Education providers need robust mechanisms for assessment of both knowledge and professional performance, and where all efforts to provide advice and support have failed, to call a halt to a professional career before patients, clients or service users are harmed.

The literature indicates a general aversion to confronting students who exhibit unprofessional patterns of behaviour, and a reluctance to consider termination of studies or expulsion. A number of education providers, particularly in north America, appear to have no system for terminating the studies or dismissing students [64]. Only uncommonly do publications on remediation contemplate the possibility of an unsuccessful outcome. A notable exception is a chapter in a textbook on remediation in medical education entitled "The prognosis is poor: when to give up" [83], which helpfully includes three examples of letters to be sent to seriously struggling trainees which clearly identify the deficits, set out the necessary actions, and provide a clear warning about possible termination of studies in the event of an unsatisfactory outcome. Such letters are particularly important given the need to give students clear warnings about what they have done wrong, what they need to do in the future, and what could happen if they fail to respond to support, advice and warnings [80].

The words "fail" and "failure" are generally seen as negative by both students and educators, sometimes leading an unfortunate reluctance to use the word "fail". The use of alternative euphemisms for failure such as "deferred success" do not help students cope with reality and learn from their experience. The fact is that failure can have a positive outcome, both for learners and education providers, and it has been argued that some degree of attrition (meaning not completing a programme) is inevitable if one is to maintain standards within a profession [58]. Failure is a necessary possibility in any assessment process, and without it passing has little value [34].

The language used to describe the fact that some students leave courses without completing their studies has varied over the years, changing from "wastage" in the 1960s [84] to "attrition" more recently [58]. However, both terms have negative connotations. Wastage suggests that failure to complete represents as waste of time and resources, even though the process of discovering that a student is not suited to a particular career may itself be invaluable and prevent all manner of negative consequences. Attrition on the other hand has a more military association, being a term that refers to a military strategy which states that to win a war, the enemy must be worn down to the point of collapse by continuous losses of in personnel and material. As pointed out by Urwin et al [58], neither term seems appropriate to describe the human processes involved in students leaving a course of study. Descriptions of "devastated students" with their hopes "dashed" have been criticised as being too simplistic, and some who leave may have simply decided they have made a wrong career choice or leave for a variety of reasons that would not warrant reference to devastation or dashed hopes. In short, whilst failure may be a negative outcome for many, it may bring benefits to others, for example unwilling students who have been reluctantly propelled in an unwanted direction by pressure from their parents.

Allowing unsuitable students to proceed does them no favours, and is likely to be setting them up for serious professional difficulties after entering professional practice. However reluctance to report unprofessional behaviour is well recognised, even when the need to identify, manage and remediate unprofessional behaviour has been emphasised [10, 13]. Students have themselves expressed concern at the reluctance to report concerns. As an example, a student writing about "keeping mum", Shackshaft, a medical student in London, wrote: "This failure to fail" not only affects those who are underperforming and allows for potentially unsafe practice in our future doctors, its effects spread to the whole cohort of medical students. If we as students feel that we cannot trust our supervisors to inform us when we are underperforming, we are left in a constant state of uncertainty, wondering if our skills are truly at the expected level. The lack of any negative feedback undermines and devalues any positive feedback that is received, resulting in an overall loss of confidence in our abilities" [18]. This student added "This widespread reluctance to give negative feedback and deliver an undesirable message results in a perpetuation of this "Mum effect" in the next generation of doctors. As medical students, not receiving such news about ourselves deprives us of examples and role models to help us to learn how to deliver constructive feedback to our own peers or future students. I can see fellow medical students feeling completely unable to do just this". Some staff are reluctant to provide negative feedback, fearing that it will cause offence, but as put rather graphically by one student "not telling me something because you "didn't want to piss me off" is probably the best way to piss me off".

Development of processes which support assessors to fail underperforming students is essential to promote public confidence in professionals. There may be an analogy with patient safety systems and incident reporting, where it is recognised that the safest health care providers are those that actively promote the reporting of incidents. It would be novel (to the point of absurdity) to suggest that the very best health and social education providers are the ones that fail and expel the highest proportion of students, but a provider that never ever failed a student would be unlikely to promote public confidence in its graduates.

Conclusions

Numerous barriers to failing an unsatisfactory health or social care student have been identified. These include an unwillingness to document negative observations, a lack of knowledge as to what to document, a lack of remediation options and a lack of confidence in remediation as a way of achieving change, negative past experiences of appeals processes and a lack of confidence in their outcome, and a fear of legal challenges. Educators need specific training to optimise the quality of their decision making, and to reduce the incidence of failing to fail students.

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