

ORIGINAL RESEARCH

A concept analysis of “Reluctance to fail”

Sarah A. Prichard *, Peggy Ward-Smith

University of Missouri Kansas City, United States

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ABSTRACT

Background: Academic success in programs of nursing requires successful completion of didactic and clinical activities. Failure, in didactic situations, is objectively determined. Clinical failure is determined subjectively, which may expose the competency and reputation of the clinical faculty. This scenario can result in a hesitancy, or a reluctance to fail a student. Graduation may occur in the presence of limited clinical competency resulting in new graduates who are not adequately prepared for professional nursing practice.

Methods: Exploring the concept of reluctance to fail will provide a conceptual definition based on uses of the concept found in research studies. Walker and Avant (2011) describe an eight step concept analysis process which will be utilized to determine the defining attributes, antecedents, consequences and empirical referents of the concept of reluctance to fail.

Results: The result of this concept analysis is a conceptual model depicting reluctance to fail as a circular phenomenon with various elements. Guided by the intervention needed to address the deficiency, these elements may be placed in one of three categories: education of faculty, role modeling, and peer support.

Conclusions: Education of clinical faculty will diminish the unwillingness, and hesitancy elements. Role modeling activities will prevent fear as rationale for reluctance to fail. Peer support provides emotional support when guilt for assigning a failing grade occurs. Future research must be conducted to identify factors responsible for faculty reluctance to assign failing grades, as well as the effectiveness of these interventions.

Key Words: Reluctance to fail, Nursing faculty, Clinical setting

1. INTRODUCTION

Academic programs of nursing have didactic and clinical requirements to assess student knowledge. To be successful in nursing programs, students must achieve passing grades in both didactic and clinical courses.^[1] Didactic learning outcomes are objectively measured and failure occurs when minimum standards are not met.^[1] Didactic course failure occurs more frequently than clinical course failure where student learning outcomes (SLO's) are subjectively measured.^[1,2] The subjectivity of measuring clinical SLO's has been linked to clinical faculty and preceptors describing a reluctance to fail.^[1,2] This makes it challenging to determine

if a student has actually met the minimum standards to pass the course.^[1,3] A concept analysis was completed to identify barriers that result in a reluctance to fail a student in a clinical course.

The reluctance to fail students in nursing education has become an increasingly important issue.^[3,4] Outcomes associated with the reluctance to fail include decreased patient safety, distrust of the nursing profession by society, and transition of unsafe students to professional practice.^[3] Nursing faculty, responsible for assigning grades at the conclusion of clinical, capstone, or preceptorship experiences, are the gatekeepers for this scenario.^[3] Typically, clinical grades

*Correspondence: Sarah A. Prichard; Email: sam2mf@mail.umkc.edu; Address: University of Missouri Kansas City, United States.

are determined by the clinical faculty, the preceptor, and the student using a skills performance matrix and a clinical evaluation tool.^[1] These evaluation tools fail to specifically describe performance behaviors indicative of successful completion of a clinical course.^[1] Hunt and associates,^[3] as well as Larocque and colleagues,^[4] describe the issue of reluctance to fail as prevalent among faculty and preceptors.

The need for objective evaluation tools

Few validated evaluation tools have identified factors that contribute to faculty reluctance to assign failing grades.^[1,3] Most clinical evaluations are rooted in academic student learning outcomes and do not describe actual clinical behaviors.^[1] In medicine, initiatives are needed to improve faculty preparation to evaluate students in practice.^[5] Fazio et al.^[6] conducted a study surveying grade inflation in internal medicine clerkships. The results indicated that 55% of internal medicine clerkship directors felt grade inflation of student performance existed at their schools.^[6] Grade inflation was attributed to evaluation tools which were poorly standardized, often subjective, and lacking specific descriptions of clinical performance behaviors.^[6]

In a study conducted by Hunt et al.^[2] using nursing programs in England, failure rates from didactic courses outstripped failure rates from clinical courses by a ratio of more than four to one. The study examined failure rates of didactic courses and clinical courses in 27 universities with pre-registration nursing programs in England.^[2] Data analysis determined that failure rates from didactic courses were as high as 47.4% while only 25.2% of students received failing grades in clinical courses.^[2] The study suggests grade inflation exists among nursing faculty and the phenomenon of reluctance to fail is prevalent in nursing education.

2. METHODS

2.1 Concept selection

The concept of reluctance to fail was selected due to its relevance to the context of poor student clinical performance and to understand reluctance to fail behaviors of faculty in clinical courses.^[3] The concepts *lack of support* and *guidance* were considered for analysis, but were discarded due to interpretation of these terms as antecedents to reluctance to fail. As Larocque and Luhanga^[3] and Luhanga et al.^[4] affirm, lack of support or guidance for faculty considering failing students contributes to reluctance to fail. Reluctance to fail was selected due to its prevalence in the nursing and education literature discussing grading issues in both theory and practice.^[1,3,7] The reluctance of both theory and practice faculty to fail continues in nursing education indicating a need to define the concept to develop an understanding

of the ongoing issue of reluctance to fail in nursing education.^[3,4,7] Reluctance to fail is linked to statements from both preceptors and faculty regarding insufficient evaluation data to award a failing grade.^[1]

2.2 Review of literature

A literature search was conducted utilizing the databases of Academic Search Premier, CINAHL, Ebscohost, MedLine, Ovid, ProQuest, PubMed, and Science Direct. Search terms initially included baccalaureate program, clinical, concept analysis, evaluation, evaluation tools, faculty, fail, medicine, nursing education, preceptor, preceptorships, reluctance, resistance, senior level student, student, and student performance. Each term used individually in all combinations, identified 42 articles. Limiting these results by adding the keywords of clinical setting, clinical faculty, and reluctance to fail resulted in 14 research articles, readily available, and in English. These articles comprised the literature used for the concept analysis. Concept analysis was conducted utilizing Walker and Avant's^[8] eight step method to determine the uses, defining attributes, antecedents, consequences and empirical referents of the concept of reluctance to fail. The purpose of utilizing Walker and Avant's method for concept analysis was to identify as many possible uses of the concept of reluctance to fail in order to provide insight into the current issue of failure to fail in nursing education.

3. RESULTS

3.1 Uses of the concept

3.1.1 General

Reluctance describes an unwillingness or disinclination to do something, and hesitancy describes an inability to complete a task like assign a failing grade.^[7] Words that are similar to reluctance include foot-dragging, lack of enthusiasm, and averseness.^[7,9] Reluctance is also demonstrated by a lack of motivation to do something, such as recover from a disease like anorexia nervosa.^[9] Williams et al.^[10] conducted a literature review about benchmarking reluctance in business and described "benchmarking reluctance" as halting the pursuit of best practices in business organizations.^[10] Best practices were identified as strategic planning, creative thinking to generate increased revenue, and increasing productivity.^[10] Those exhibiting benchmarking reluctance were resistant and unengaged during the processes of change, and did not support organizational growth, knowledge transfer, or cost effective solutions.^[10]

3.1.2 In academic settings

Reluctance in academic settings illustrates faculty unwillingness to change, improve teaching practices, accept new teaching strategies or develop new curriculum blueprints in

all levels of education.^[11] Development of new teaching strategies and curriculum requires a significant amount of time that contributes to unwillingness to perform these activities.^[11] Many faculty who have graduated from teacher education institutions exhibit reluctance to fail students frequently in didactic courses.^[11] This is due to a shift in faculty judgments about student performance toward judgments of faculty personal worth.^[11] When faced with failing a student who has cheated or displayed academic dishonesty, few faculty actually failed the student. Of the over 75% of faculty who witnessed academic dishonesty and cheating behaviors, only approximately 9% of these faculty actually failed the student.^[11] The faculty preferred to handle the incident privately and was reluctant to involve the academic institution and its protocols.

3.1.3 In nursing education

In nursing education, reluctance to fail is described by faculty as being unwilling or hesitant to assign failing grades, feelings of guilt for failing a student, and fear of student retaliation.^[4,12] Faculty who experience failing a student often feel guilty and blame themselves for the student failure.^[12] Many times faculty feel as if they have let the student down, and feel guilty for assigning a failing grade when other faculty did not.^[12] Faculty who do fail students have supportive relationships with clinical course supervisors and understand the need to collect supporting evidence to justify failing the student in an effort to exhibit due process.^[4,12] However, this due process feels as though faculty is building evidence against the student, and are not connected to the student but enveloped in the failure process often leading to unwillingness to complete the process of assigning a failing grade.^[12]

Faculty are often hesitant to begin the process of failing a student, particularly when other faculty have not assigned failing grades to the student.^[12] This often occurs as students near completion of the nursing program because faculty feel that if the student has progressed through the majority of the program, a failing grade would be extremely detrimental to their future nursing career.^[12] Fear is also a strong contributor to faculty reluctance to fail. Many faculty fear retaliation from students if the student is assigned a failing grade, especially if the student is close to graduation from the nursing program.^[3] Students may retaliate in the form of formal litigation against the nursing program or faculty.^[3] Thus, fear of student retaliation may actually cause faculty to reconsider the decision to award a failing grade.^[3]

3.1.4 In clinical courses

In clinical courses, reluctance to fail is demonstrated by hesitancy to fail nursing students displaying unsafe practice be-

haviors.^[3] Preceptorship models of clinical education leave faculty with little time to observe the full breadth of student's clinical knowledge and skills, leaving this to be evaluated by the preceptor.^[3] Faculty must communicate regularly with preceptors regarding student clinical performance, and if this does not occur, faculty are hesitant to assign failing grades.^[3] Faculty may also be unwilling to communicate with preceptors, clinical course supervisors, and other nursing staff about student clinical performance, particularly if the student has never failed previous clinical courses.^[12] Thus, hesitancy and unwillingness of faculty leads to increased reluctance to assign failing grades to nursing students in clinical courses.

Fear of retaliation from students by faculty and preceptors is also a strong contributor of reluctance to fail in clinical courses.^[3] Preceptors identified fear of providing an evaluation of student performance that was different from the faculty's evaluation as having an impact in their decision to assign a failing grade.^[13] Faculty feared student retaliation when deciding to assign failing grades particularly if the student was nearing the completion of the nursing program.^[13] Faculty expressed feelings of guilt when assigning failing grades to students in clinical courses, especially senior level students in the final clinical capstone or preceptorship experience.^[3,12] In fact, faculty in senior level clinical courses were least likely to assign failing grades due to feelings of guilt about potentially ruining the student's career in nursing.^[3,12]

3.1.5 Defining attributes

The defining attributes of the concept include unwillingness, hesitancy, guilt, and fear. Unwillingness and hesitancy occur when attempting to complete tasks, such as assign failing grades.^[13] Often, faculty feel guilty when considering the decision to assign a failing grade, feeling as though they let the student down, which contributes to reluctance.^[12] This guilt often increases when the student is closer to completion of the nursing program.^[3,12] Faculty and preceptors also fear retaliation from students if they assign a failing grade, thus increasing reluctance to fail.^[3]

3.1.6 Model case

A model case serves to provide an example of the concept utilizing all of the defining attributes of the concept.^[8] The model case for the concept of reluctance to fail is as follows:

A clinical faculty member is teaching a baccalaureate nursing clinical course for the first time. As the course progresses, the faculty member has observed several instances of unsafe practice behaviors in a student. This perception is validated when the clinical preceptor also expresses concern to the faculty member. While

the faculty member determines that the student is failing the course, there is uncertainty with respect to the academic process of awarding a failing grade, and a concern about the timing of the process. The dilemma for the faculty member surrounds the professional fear of failing the student during this clinical rotation; yet allowing the student to graduate has the potential for undesirable patient outcomes. As an adjunct faculty person, there is little awareness of previous assessment summaries, and a concern that if the student has gotten this far, are expectations unrealistic? Thus, the faculty member does not discuss the student's progress with the course supervisor and awards a passing grade for the course.

3.1.7 Antecedents and consequences

The antecedents to the concept of reluctance to fail are lack of support and guidance, inexperience, time, and the organizational culture in nursing education institutions. Faculty in nursing education are reluctant to fail students due to lack of guidance and support from academic institutions regarding the situation that occurs when assigning a failing grade, and are sometimes inexperienced in evaluating student performance.^[3,4] Luhanga et al.^[7] conducted a study describing preceptors who were reluctant to assign failing grades to students in preceptorships. Study results describe preceptors as inexperienced and feeling ill-prepared to evaluate students fully, and when faced with the decision to assign a failing grade, electing to pass the student.^[7] Preceptors in the study described their reluctance as giving students the "benefit of the doubt" when they exhibited marginal or unsafe behavior in practice.^[7] However, clinical faculty also tend to give students the "benefit of the doubt" in preceptorship courses due to lack of sufficient time to observe student clinical behaviors and, as such, do not assign failing grades.^[3]

Faculty in medical programs report feeling ill-prepared to fail students participating in internal medicine clerkships due to poorly standardized evaluation tools.^[6] Evaluation tools describe objective behaviors that do not accurately portray subjective measurements of clerkship performance.^[6] Lack of appropriate evaluation tools in internal medicine clerkships has contributed to grade inflation and reluctance to assign failing grades.^[6] In physical therapy clinical settings, preceptors feel confused when deciding to fail a student based on current evaluation tools.^[13] Preceptors are often not given an explanation or orientation to the evaluation tools utilized and have difficulty relating clinical performance behaviors to objectively defined learning outcomes on evaluation tools.^[13]

Physical therapy preceptors are reluctant to assign failing grades utilizing current clinical evaluation tools.^[13]

Advanced practice nurse preceptors are reluctant to fail students due to unwillingness to devote time to the process of failing a student.^[14] It is extremely time consuming to consistently observe student clinical behaviors, discuss student performance with preceptors, and obtain information from other nurses on the clinical unit in regards to the safety and quality of student performance.^[14] In didactic courses, nurse educators are reluctant to take time to collect supporting evidence needed in the decision to assign a failing grade. Evidence often includes conversations and documentation from previous faculty, observation of student behaviors, and lengthy discussions with supervisors or course coordinators.^[12] Retention and progression of students is an important aspect of nursing education and faculty assigning failing grades experience reluctance in an effort to retain students in the program.^[12,15] A culture of reluctance to fail within nursing education institutions contributes to reluctance among faculty considering assigning failing grades.^[7,15] The organizational culture of nursing programs impacts many faculty decisions including the assignment of failing grades to students in both didactic and clinical courses.^[15]

An important consequence of reluctance to fail is graduation of unsafe students from the nursing program.^[3,7] Graduation of unsafe students contributes to undesirable patient outcomes because unsafe practice behaviors will likely continue upon the transition to professional practice.^[3] Another consequence of reluctance to fail is distrust of the nursing profession by society.^[3] Nurses are among the most trusted individuals in the workforce and society entrusts their health to the clinical competence of nurses in all stages of life.^[3] When students who should have failed are allowed to graduate and transition to practice, lack of trust begins.^[3] The issue of reluctance to fail in nursing education has important implications for the future of the nursing profession.

3.2 Empirical referents

Empirical referents are those categories of phenomena that by existing, demonstrate the presence of the concept itself.^[8] Unwillingness is a key empirical referent to the concept of reluctance. Without unwillingness to complete a task, reluctance is not demonstrated.^[7] Lack of motivation contributes to unwillingness to complete a task, which leads to reluctance.^[11] Resistance is an empirical referent to reluctance because resistance is the refusal to accept a new idea or concept and is also demonstrated in the unwillingness to change.^[9]

4. DISCUSSION AND SUMMARY

4.1 Model

Using the research-identified attributes, a model was developed (see Figure 1). Reluctance to fail is perceived as a circular phenomenon, in which various elements can impact. Hypothetically, the elements have been placed within one of three categories, based on the focus of the method of intervention needed. Interventions which focus on peer support

will impact the element of guilt. Education, specific to the role of clinical faculty, and the academic policies specific to failure, will diminish the unwillingness, and hesitancy elements. Finally, role modeling activities will prevent fear as the rationale for reluctance to fail. Research is needed that explores, develops, and evaluates these interventions. Future research must also determine subjective and objective factors which contribute to faculty reluctance to assign failing grades.

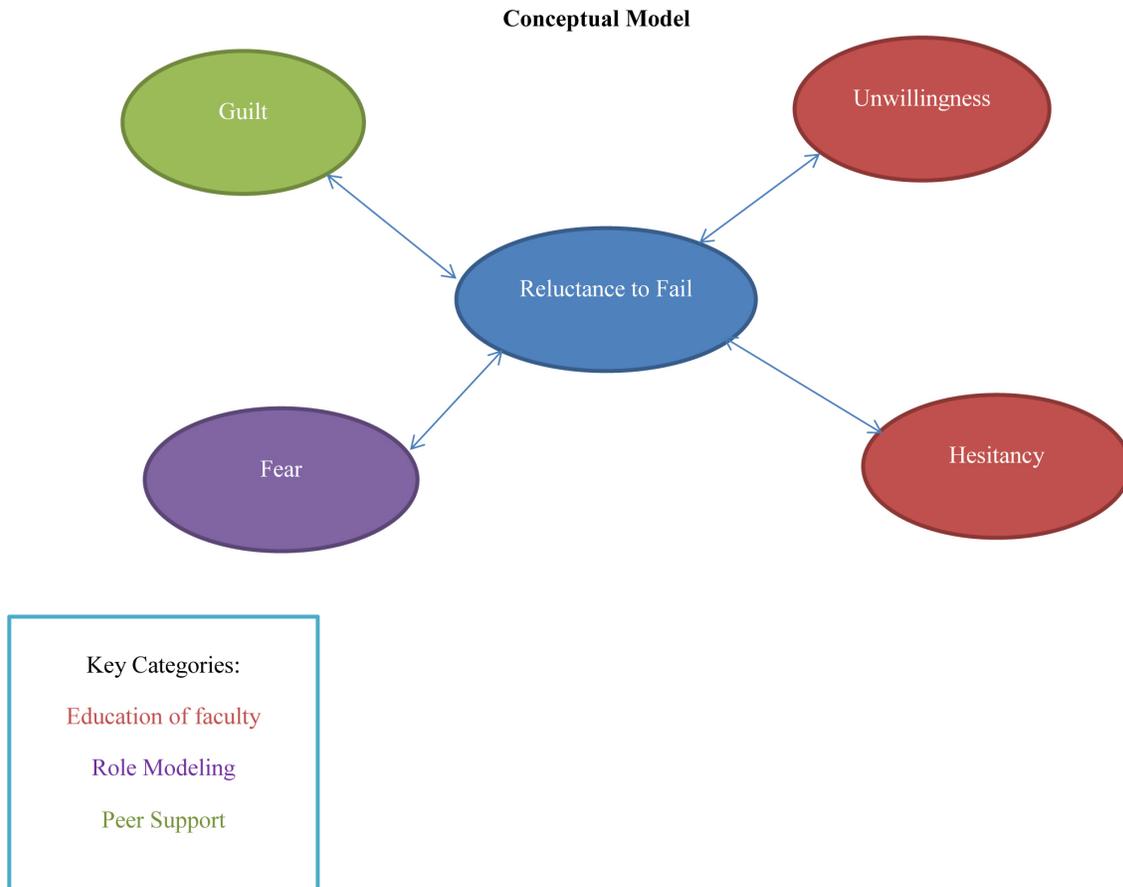


Figure 1. Conceptual Model

4.2 Summary

A concept analysis was conducted to analyze the concept of reluctance to fail and relate it to the current issue of failure to fail in nursing education. Reluctance is defined as the unwillingness or disinclination to do something.^[7] The defining attributes of the concept of reluctance to fail include unwillingness, hesitancy, fear, and guilt. A model case was developed to characterize the concept of reluctance to fail. Antecedents for the concept of reluctance to fail include lack of support and guidance, inexperience, time, and the

organizational culture of nursing education institutions. Consequences include graduation of unsafe students from the nursing program, and distrust of the nursing profession by society. Unwillingness, lack of motivation, and resistance were identified as empirical referents to the concept of reluctance. Reluctance is the major contributor toward the issue of failure to fail in nursing education.^[1,3]

CONFLICTS OF INTEREST DISCLOSURE

The authors declare that there is no conflict of interest.

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