

WHY EMS LEARNERS SHUT DOWN IN SCENARIOS

And What To Do About It

The Learner Vital Signs Framework

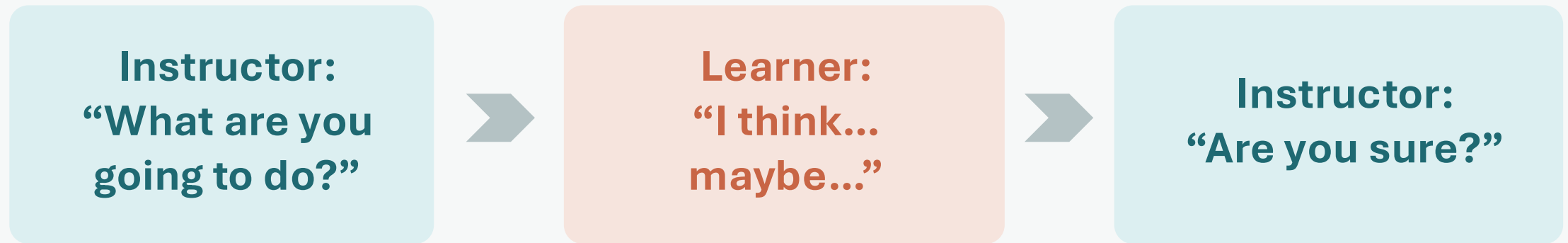
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Opening Case

OPENING CASE
A paramedic student recognizes respiratory distress and begins appropriately. Then the patient deteriorates.



The learner stops talking, looks toward their partner, and begins waiting for direction.



What Happened?

① The Slido app must be installed on every computer you're presenting from

slido

We do not have enough information yet.

“Shutdown” is an observable behavior involving reduced communication, decision-making, engagement, or access to previously demonstrated thinking.

Not every pause, silence, or hesitation is shutdown.

Observe first. Interpret second.

Learning Objectives

Recognize observable learner behaviors without prematurely assigning a cause.

Check the five learner vital signs before choosing an intervention.

Match cueing, coaching, assessment, pausing, or stopping to the likely problem.

Improve scenario practices while preserving rigor, accountability, and independent thinking.

The Learner Vital Signs

1

Capacity

Cognitive Load

2

Clarity

Assessment Ambiguity

3

Threat

Social – Evaluative

4

Instruction

Instructor Interference

5

Competence

Readiness /
Competence Gap

These are not diagnoses. They are prompts that slow down our assumptions.

Performance in Context

Observed performance

Influenced
by

**Knowledge
& Skill**

Capacity

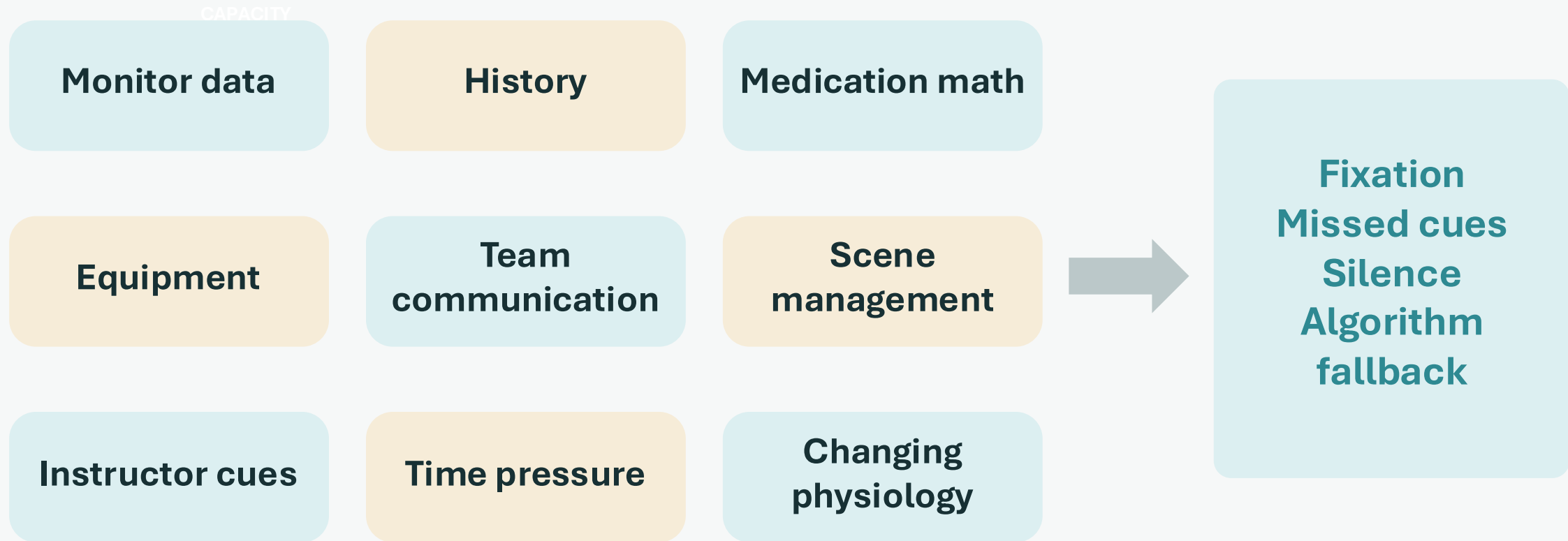
Context

**Perceived
Consequences**

Instruction

Poor performance matters. The question is whether it reflects a competence gap, performance interference, or both.

Vital Sign 1: Capacity



Keep necessary difficulty. Remove irrelevant load.

Vital Sign 2: Clarity

Explicit message

“This is formative.”



Implicit signals

Checklist / Rubric

Faculty silence

Cameras

Peer observers

Remediation language

Unknown consequences

Learning scenario • Formative assessment • Summative assessment

Vital Sign 3: Threat

“Am I embarrassing myself?”

“Am I failing?”

“Should I commit to this?”

“Does everyone else know this?”

“What does the instructor want?”

Attention can shift from clinical reasoning to impression management.

Vital Sign 4: Instruction

“Are you sure?”

“Anything else?”

Raised eyebrow

Long sigh

“Interesting...”

Abrupt rescue

The instructor’s face becomes another vital sign.

Vital Sign 5: Competence

- Prerequisite knowledge is missing
- Procedural skill is not automatic enough
- Previous learning was not retained
- Complexity exceeds current level
- Preparation was inadequate

**Psychological safety
does not fix a
knowledge gap.**

Support ≠ rescue.

Same behavior. Different vital sign.

Learner goes quiet after three new cues arrive at once.

Capacity

Learner keeps asking, “Does this count?”

Clarity

Learner looks at peers before every decision.

Threat

Learner changes a correct answer after a raised eyebrow.

Instruction

Learner cannot explain the underlying physiology.

Competence

Case 1: The silent cardiology student

The learner recognizes a STEMI and states an appropriate plan.

Instructor: “Are you sure that’s what you want to do?”



Learner changes the interpretation to pericarditis.

Teaching move: “Walk me through what you’re seeing.”

Assessment move: say nothing; observe.

Case 2: Pediatric Respiratory Distress

History

Airway

**Weight-based
dose**

Monitor changes

Parent yelling

**Transport
decision**

**Team
coordination**

**Instructor
questions**

The learner suddenly cannot calculate a dose they calculated correctly yesterday.



What type of problem is this?

What Can Change Without Making it Easier?

**Reduce irrelevant
load**

**Pause intrusive
questioning**

**Allow team
delegation**

**Use realistic
cognitive aids**

**Scaffold
complexity**

Case 3: “It’s Just Practice”

**Instructor says:
“This is Just
Practice.”**



Evaluation form being completed

**Poor performance may trigger
remediation**

**Performance discussed in faculty
meetings**

**The explicit message and the implicit signals contradict each other.
Learners usually believe the consequences they can see.**

Better Participation Doesn't Just Mean More Talking

Thinking

Verbalizes reasoning when doing so supports the task.

Deciding

Commits to a clinical plan instead of repeatedly seeking approval.

Communicating

Shares information, assigns roles, and closes the loop with the team.

Questioning

Names uncertainty or asks for information that is actually needed.

Reassessing

Checks whether the patient changed after an intervention or decision.

Recovering

Recognizes an error, adjusts, and re-engages instead of giving up.

Participation = active engagement in thinking, communicating, deciding, reassessing, and recovering—not compliance or constant talking.

Choose the Smallest Useful Intervention

Capacity

Reduce irrelevant load or pause competing input.

Clarity

Clarify purpose, rules, stakes, or faculty role.

Threat

Reduce unnecessary public threat; normalize uncertainty.

Instruction

Stop signaling; use a neutral prompt or silence.

Competence

Teach, remediate, scaffold, or reassess readiness.

Return responsibility for the thinking to the learner—not simply get them moving again.

Cue ≠ Coaching ≠ Assessment

1 Cue

Helps the learner access knowledge they may already have.

Example: “Reassess your patient.”

2 Coaching

Builds a skill or reasoning process during learning.

Example: “Talk me through what you’re seeing.”

3 Assessment

Allows independent performance to be observed.

Example: observe without rescuing.

Mix these constantly and you lose both learning clarity and assessment meaning.

Continue, Cue, Coach/Pause, or Stop?

CONTINUE

Learner is engaged; recovery is plausible; continued performance still serves the objective.

CUE

They appear stuck but may be able to access existing knowledge with minimal help.

COACH / PAUSE

This is a learning event and reasoning or skill needs active development.

STOP / RETEACH

Continued performance no longer serves the objective, or the prerequisite knowledge/skill is not there.

Same learner. Same scenario. Different instructional purpose = different intervention.

Small Language Shifts Can Keep Reasoning Visible

INSTEAD OF

“Are you sure?”



“You forgot something.”



“Why would you do that?”



“You should know this.”



“What else?”



TRY

“Talk me through your thinking.”

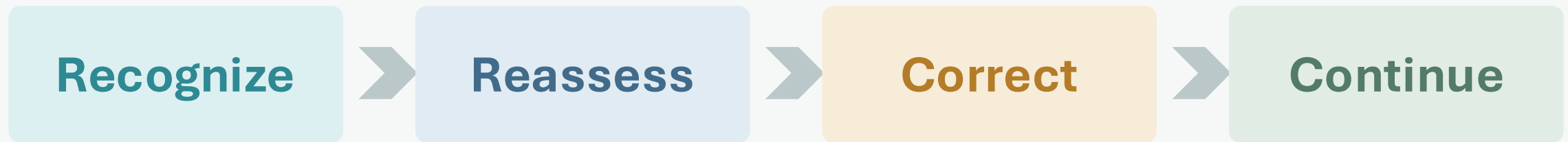
“Reassess your patient.”

“What led you to that decision?”

“Where did your reasoning become uncertain?”

“What information matters most right now?”

Do Not Make the First Error the End of the Learning Opportunity



Error recovery may be a higher standard than error avoidance.

Build the Conditions Before the Learner Shuts Down

1 Before

Clarify purpose and stakes.

State when faculty will intervene.

Name available resources and cognitive aids.

Make success criteria visible without giving away the case.

2 During

Observe before interpreting.

Check the five vital signs.

Use the smallest useful intervention.

Avoid unintended cueing.

Allow recovery when it serves the objective.

3 After

Explore the learner's reasoning.

Identify where thinking changed.

Separate competence gaps from performance interference.

Plan deliberate practice or reassessment.

Do Not Make Learners Adapt to the Instructor Lottery

- 1 What prompts or cues are permitted?
- 2 When will faculty intervene?
- 3 What kinds of error trigger a pause or stop?
- 4 How will observed performance be documented and used?

Consistency improves both learner clarity and assessment meaning.

Return to the Opening Case

1 Capacity

Can they process what is being asked?

2 Clarity

Do they understand the goal, stakes, and rules?

3 Threat

Managing the patient—or managing perception?

4 Instruction

Are faculty behaviors helping thinking or distorting it?

5 Competence

Do they have the required knowledge and skill?

The learner's behavior is the starting point—not the conclusion.

Help Us Understand How EMS Educators and Students Think About a Safe Learning Environment in Simulation

What we are studying

An ongoing Q-methodology dissertation study examines how EMS educators and students conceptualize psychological safety in simulation—especially at the intersection of safety, accountability, realism, and performance.

Why your participation matters

We need variation in viewpoints—not just more of the same perspective.



THE TAKEAWAY

Check the Vital Signs Before You Label the Learner.

Capacity • Clarity • Threat • Instruction • Competence

Then choose the smallest intervention that preserves the learner's opportunity to think.

Rigor and psychological safety are not opposites. Poorly designed instruction can undermine both.

References

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Note: the webinar framework synthesizes learning-science and simulation concepts into a practical faculty-development tool; it should not be presented as a validated diagnostic instrument.