

# Mastering the Preceptor Role: Challenges of Clinical Teaching

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## ABSTRACT

This article aims to help both experienced and new preceptors become more effective teachers while maintaining their clinical workloads. A variety of strategies is essential to increase teaching effectiveness and decrease stress for the busy preceptor who juggles the roles of teacher and clinician. The article will begin with a review of role expectations and role strain factors for student, faculty, and preceptor. Principles of clinical teaching will be identified, followed by some strategies for teaching on busy days and concluding with suggestions for dealing with difficult students. *J Pediatr Health Care.* (2006) , 172-183.

Guided clinical learning experiences are essential to nurse practitioner (NP) education. The goal is to prepare clinicians to manage care with optimal health outcomes. The preceptorship has proved to be a highly useful strategy for clinical education. It allows education to be individualized, links classroom knowledge to real patient management problems, and provides for role modeling as the student develops standards and strategies for practice.

In the United States, preceptorships involve more than 500 hours of supervised clinical practice in the particular NP specialty with preceptors who are either experienced NPs or physicians in the same specialty. The student and preceptor have a one-to-one relationship. In the typical clinical practice teaching episode, the student does the assessment and presents the case to the preceptor with diagnosis and plan outlined, the preceptor validates the assessment and plan, the student implements the plan with assistance as needed, and the preceptor helps the student reflect on the case and its implications. As the student works with the preceptor over an academic term or more, he or she is expected to increase knowledge and skills, refine practice efficiency and effectiveness, and become increasingly independent in managing patient care. The preceptor provides constant feedback and support to the student and evaluation data to both the student and faculty ([National Organization of Nurse Practitioner Faculty, 2000](#)).

This type of teaching is not without problems, however. [Irby \(1995\)](#) noted that teaching in the clinical setting often occurs at a rapid pace with multiple demands on the preceptor; is variable in teaching and learning opportunities as cases vary unpredictably in number, type, and complexity; and

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has a relative lack of continuity. In a busy setting, there may be limited time for teaching and feedback. In turn, the student may not find learning to be collaborative with the preceptor, may lack opportunities and time for reflection, and may find that independent learning is not at an optimal pace given the student's learning style.

A previous study of the preceptor as mentor (Beauchesne & Howard, 1996) concluded that preceptors may need help in identifying an individual student's learning style and in determining their own leadership style. Preceptor development is worth the time and energy needed because, if it is done successfully, the preceptor, student, and faculty all will benefit from more efficient, less stressful teaching by preceptors in clinical settings.

A survey by Burns (2003) for the Association of Faculties of Pediatric Nurse Practitioner Faculties of 350 preceptors attending the National Association of Pediatric Nurse Practitioners Annual Conference found that 89% preceptored because they felt an obligation to the PNP specialty and 85% did so because they liked teaching. Ninety-four percent said that they planned to continue precepting. Thus, despite the problems, preceptors find this role to be inherently satisfying.

This article addresses several strategies to increase teaching effectiveness while decreasing stress as the busy preceptor juggles the roles of teacher and clinician. It reviews role expectations and role strain factors for student, faculty, and preceptor; identifies some key principles of clinical teaching; suggests a variety of strategies for teaching on busy days; and concludes with suggestions for dealing with the difficult student. The goal is to help both experienced and new preceptors become more effective teachers while maintaining their clinical workloads.

## **ROLE EXPECTATIONS: STUDENT, FACULTY, PRECEPTOR**

The roles of student, preceptor, and faculty must work in synchrony for good learning outcomes. The setting also is important and places limitations on time, space, and access to patients. The student is expected to be an active adult learner; the faculty is expected to assess the student's needs and arrange for a preceptorship learning environment consistent with program goals and to evaluate the student's work; and the preceptor is expected to provide day-to-day clinical teaching while meeting clinical practice expectations. Meeting the expectations is not always easy for any of the parties. More detailed role expectations as well as pressures upon role performance are summarized in Table 1.

Hayes (1994) studied the preceptor role and identified qualities of good preceptors from students' perspectives. Personal characteristics included being empathic, warm, respectful, and humorous. Flexibility, fairness, dependability, consistency, and enthusiasm were valued. Students also looked favorably on preceptors who were willing to work with the beginning student, could adapt their teaching style as needed, and supported the educational program. The preceptor is expected to have current clinical skills and knowledge, help students recognize their assumptions and think through their management decisions, and model effective communication with clients that emphasizes psychosocial aspects of care. Successful teaching is a complex process that requires not only expertise in clinical content but also positive personal attributes.

## **BASICS OF CLINICAL TEACHING**

The following sections describe some general principles of teaching as well as specific strategies

that can be used by the preceptor to help the student become a safe, competent, compassionate, independent, and collaborative clinician. This teaching spans the continuum from the basics of health promotion to the management of complex conditions and issues. Thompson, Kershbaumer, and Krisman-Scott (2001) suggest that preceptors teach critical thinking skills so that the practitioner is a *competent* in taking a thorough and focused history, *compassionate* about the information gathered from the history and physical and ultimately *independent* in assessment, management, and follow-up.

## **Characteristics of Adult Learners**

Familiarity with characteristics of adult learners is critical. Many NP students come to the clinical

**Table 1. Role expectations and pressures**

Student	Faculty	Preceptor
<b>Role expectations</b>		
Arrive on time Demonstrate knowledge Ask questions Observe and learn Communicate effectively Participate in activities Respect confidentiality Engage in learning	Listen and observe Provide supervision Provide feedback Verify understanding Set boundaries Monitor progress Provide support Set expectations Give encouragement Provide resources Teach and evaluate	Orient students Establish rapport Build trust Provide supervision Evaluate performance Delegate tasks Provide feedback Support learning
<b>Role pressures: potential areas of difficulty</b>		
Manage time Work with diverse learners Balance teaching and clinical work Address individual needs	Listen and observe Set boundaries Evaluate performance Provide feedback Support learning Teach and evaluate Provide resources Give encouragement Provide resources Teach and evaluate	

sentential critical thinking skills. They need to understand the “why” behind what they are being taught and what they are expected to do (Knowles, 1984; Nebraska Institute for the Study of Adult Literacy, 2005). For example, actually prescribing immunizations is more valuable than reading about the process or watching the preceptor perform the activity. Adults typically learn better when the topic is of immediate value.

**General Approaches for Adult Learners**

Just as there are principles of adult learning, there also are principles of teaching adults in the clinical setting. The most commonly described teaching methods are the “sink or swim” approach

and the “manipulated structure” approach (Davis, Sawin, & Dunn, 1993). Use of these approaches generally change over time as the student develops more skills and confidence. In the “sink or swim” approach, the student NP is exposed to a variety of patient encounters and is expected to conduct visits independently with no visible support. With this approach there is minimal pre-visit teaching but, obviously, the preceptor is ultimately responsible for important decisions and is available at all times for back up. In the structured approach, patients are carefully selected, based on the student’s previous experience and skills. There is much pre-visit and post-visit consultation with the preceptor. Cases increase in number and

complexity as clinical skills develop. Preceptors generally teach as they like to learn but need to recognize that their students may not share the same perspectives.

Several important factors must be considered when deciding which method of teaching to use. It is helpful to consider the level of the student. A first-semester, first-year student may function best with a structured approach, whereas a final-term student is likely to be ready to “swim.” It is appropriate to ask NP students what approach they prefer. If new students opt for the “sink or swim” approach, it is critical that they be closely monitored until the preceptor is comfortable with their skills. Observing those students independently conduct a visit may allow

the preceptor to judge their current abilities and subsequently structure clinical experiences according to abilities. Preceptors may find that consultation with university faculty is useful when deciding which approach to use. An important principle to keep in mind regarding use of teaching styles is that anxiety may result from a learning situation requiring high independence with low experience, while frustration occurs when low independence is allowed for students with high experience levels.

### Principles of Clinical Teaching

After determining what specific teaching approach is best for the student and for the clinical setting, it is useful to apply general principles of clinical teaching. Some basic tenets of learning include the following:

- Learning is evolutionary.
- Participation, repetition, and reinforcement strengthen and enhance learning.
- Variety in learning activities increases interest and readiness to learn enhances retention.
- Immediate use of information and skills enhances retention

In addition to the personal qualities of the preceptor that have already been mentioned, preparation and planning have been noted by several authors to be key components to a successful experience for all students (Fay et al., 2001; Smith & Irby, 1997; Usatine, Nguyen, Randall, & Irby, 1997). The goal is to provide settings and experiences in which learning can occur with minimal disruption to agency operations and patient needs and expectations. Awareness of the school's goals as well as the student's personal goals is essential. Thus, there needs to be communication with faculty prior to the student's arrival and discussion of goals with the student before beginning clinical activities. Preparation of the clinical setting,

one important aspect, will be discussed later.

Regardless of whether a "sink or swim" or a "manipulated structure" approach is used, several specific strategies of teaching are useful for all levels of learners. Modeling is an effective teaching strategy (Irby, 1995). The preceptor demonstrates his or her clinical expertise when seeing patients while the beginning learner observes this process. This approach allows the student to see the reality of classroom education applied to actual patients. Modeling allows the more advanced learner to observe more subtle aspects of patient interaction, such as how one approaches difficult issues of potential physical abuse, problematic behaviors, developmental delays, and serious illness. Modeling and observation provide the preceptor and the student with the opportunity to share impressions, think through cases together, and develop differential diagnoses. It is often during this modeling experience that the preceptor may be challenged to answer the "why" questions of adult learners. However, modeling and observation are relatively passive; learners need to actually apply skills themselves to achieve mastery.

Case discussions reflect the student's ability to obtain critical histories, report pertinent physical findings, generate reasonable differential diagnoses, and develop fitting management and follow-up plans. Discussing cases allows the preceptor to determine if the student is able to incorporate past experience and schemata into new clinical situations and assess the student's level of expertise in dealing with a range of patients (Coralli, 1989; Wolpaw, Wolpaw, & Papp, 2003).

Questioning is helpful in fostering critical thinking skills. Preceptors are most effective when the questioning is not perceived as "grilling" (McGee & Irby, 1997).

Optimally, questions such as "What do you think?" and "Why do you think that?" stimulate thinking and allow the student to share observations and interpretations with the preceptor. The preceptor can help the student formulate generalizations, which then can be tested with multiple patients. Generalizations then become part of a conceptual framework, which will be useful over time (Smith & Irby, 1997).

Two types of questioningTwo typ-266(typ-5



shared with the faculty person who is responsible for grading the student's performance.

### Teaching to the Developmental Level of Students

It is important to remember that while being a preceptor is stressful, so is being a student (Yonge, Krahn, Trojan, Reid, & Haase, 2002). Examining the situation from both perspectives is one way to better understand the relationship (Papp, Markkanen, & von Bonsdorff, 2003). Ohrling and Hallberg (2000) studied students' lived experience of preceptorship. Four themes emerged as critical to learning: creating a space for learning with both time and room, providing concrete illustrations, providing for some control over the opportunities and pace of learning, and allowing time for reflection. Taking advantage of students' past experiences and expertise is helpful. Also, students' self-esteem is enhanced when they believe they are contributing to care (Hayes, 1998). Preceptors should not feel threatened if students are more expert in some areas of nursing, but rather, seize the opportunity to learn from the student. Because students are experiencing the stresses resulting from being an expert in a previous nursing area to now becoming a novice again (Benner, 1984), recognition of their expertise is helpful to them.

In order to best apply the basic strategies of effective precepting, it is important to be familiar with specific developmental levels of NP students. As with all students, they fall along a continuum of development. Students develop at different rates, react differently to different patients, and may have variability in their skills from day to day. However, there are general categories of students, each with specific skill sets (Davis et al., 1993).

• Beginning or advanced beginner students typi-

cally need preceptor support for all facets of clinical learning. They have had core course work in health assessment and perhaps some management coursework but have had little opportunity to apply classroom concepts to actual patient care. They may have difficulty in transitioning from being an expert in their previous nursing roles to being a beginner in the NP role. Some students will be reluctant to begin assessing patients independently, whereas others may be very assertive in the clinical setting, even without any prior nursing experience, using a "sink or swim" style of learning. A preceptor can use observation of the student to determine what student skills are strong and which need particular attention during the clinical experience.

Several specific strategies are useful for beginning students. Observation is a reasonable initial strategy. The student can learn much about approaches to patients as well as clinical content from observing an expert. Students must not stay in the observer mode, however. If possible, straightforward, uncomplicated, "routine" well visits should be scheduled with families who are familiar with the beginning NP role. Prior to each visit, beginning students should spend time thoroughly reviewing each chart and preparing all components of a health promotion or uncomplicated illness visit. Several patients of the same age in a session reinforce developmental milestones. General rules and conceptual frameworks around different issues and different ages then develop.

After some initial weeks or months as a beginner (depending on the intensity of the clinical experience and the student's abilities), it is expected that a student will move from beginner status to transitional learner. According to Thompson et al. (2001), this is the stage in which the preceptor is able to "step back." Transitional learners require

less input from the preceptor about the basic components of patient care. Thus, pre-visit and post-visit conferences can be more concise. The student establishes basic priorities for each visit, gathers only essential relevant data, and generally conducts visits with better efficiency and effectiveness (Davis et al., 1993). The task of the preceptor in teaching transitional students is to schedule more complex patients so that more multifaceted generalizations develop and clinical reasoning skills are

the student more independence. The relationship with the preceptor often becomes more collegial and less vertical, mutual trust develops, and the preceptor is comfortable with the student's skills and clinical judgments. Strong case presentation skills in the competent student allow the student to communicate well with other providers. It is time to let go when the preceptor is comfortable with the student's competence with patients, but the student must continue to seek help, ask appropriate questions, and search for new challenges.

### **STRATEGIES FOR TEACHING WHILE PRACTICING ON BUSY DAYS**

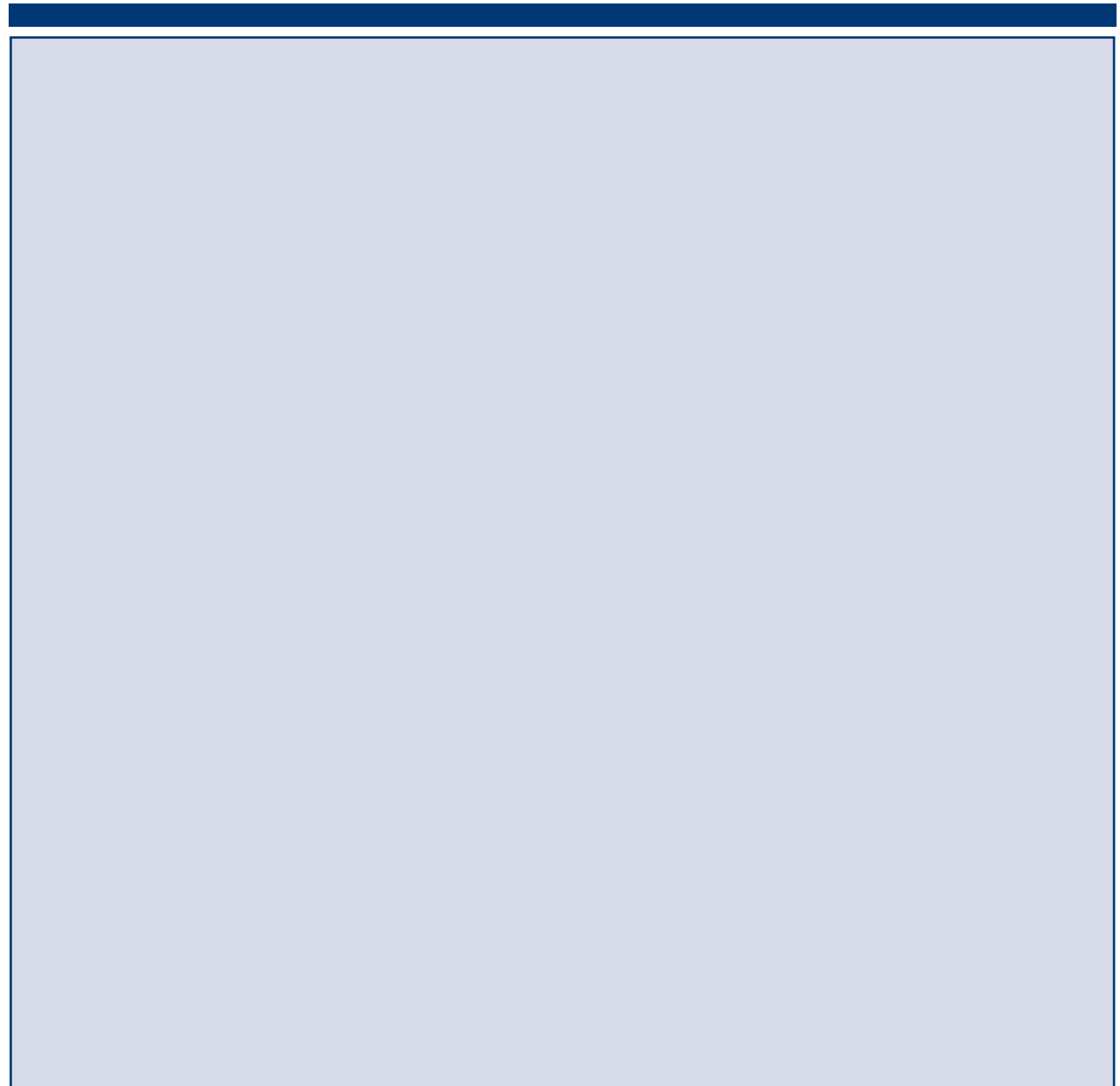
A common question posed to faculty is, "How can we have a student on a particularly busy day?" The reality is that every day is a busy day in the clinical setting. Nurses are in short supply, and faculty and preceptors are not the exceptions. Thus, all are assumed to carry heavy clinical loads. Factors in the shortage include aging faculty, increased clinical burdens that lessen time available to teach, and a major emphasis on productivity in the clinical arena (Lyon & Peach, 2001). Guberski (2000) summarizes the dilemma facing all clinical faculty: "The challenge facing current faculty is to work smarter, not necessarily harder, and to evaluate the cost-benefit ratio of our teaching strategies and application of technology" (p. 5).

Several studies have dispelled some powerful myths about precepting. Preceptors do not necessarily have a longer day or spend more time with patients, and having students does not inevitably decrease productivity (McKee, Steiner-Grossman, Burton, & Mulvihill, 1998). In fact, students may actually increase productivity (Fontana, Devine, & Kelber, 2000; Hildebrandt, 2001). However, working with a student undeniably makes a clinical day more complex. Reducing the

complexity wherever possible is the key to enjoyment of the day when a student is there.

Taking the time to develop an optimal climate for learning will pay off for all persons involved. Students learn best when there is ongoing student assessment, close communication, quick response to student's stress, trusting relationships, mutual respect, and acceptance as part of team (Myrick &

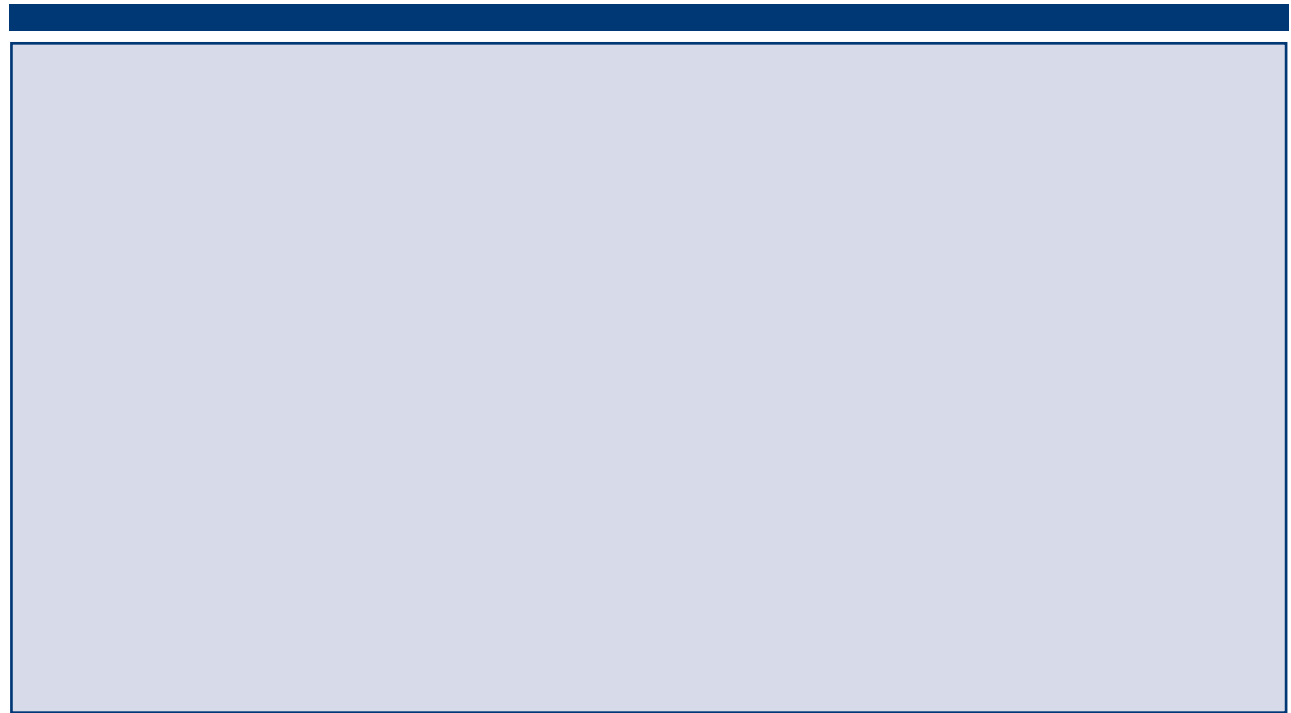




well, 2000; Yonge, Ferguson, Myrick, & Haase, 2003). Yet, it is better to share the teaching. Students benefit from enriched learning opportunities. These might include arranging for students to attend rounds, case conferences, or any other relevant meetings that focus on care. Use the library, audiovisual aids, and learning centers. Preceptors can establish a buddy







and be responsible for parts of visits; inability to transfer knowledge from one situation to another; problems with communication with preceptor, staff, and patients; and failure to improve to the next learner developmental stage.

The preceptor and faculty need data to determine if the issue is related to a poor match between preceptor, setting, and student. For example, does the preceptor use a teaching style such as “sink or swim” that generates anxiety in this particular student sufficient to severely reduce performance? Or, is the setting too hectic, limited in space, unexpectedly busy, or providing inappropriate patients? (Benzie,

preceptor

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**TABLE 3. Examples of interventions for problematic performance**

Problematic performance examples	Interventions
Un	I h s n ! n e n n , n n ! h h h s n n n n ! n n r h s n n n n n ; h s n n s s n n n n , r - n n r s n n ! n n s (C n , 1989)
L	E n r s n n ! n n r r s n n n n n n h n n n n n ! n n n ; h n n n ; ! n n ! n n r h r s n n s r n n ; s n n s n n s
D	G r s n r s n s ! n n r r r n n s s n n ( n s n r n ) n n s n ! n n ! s n h n n n ! n n ; s s n n n h r n n n n s s n n s n n ! n n s n n n n ! s ,
P	R r O n S n s h D s ! n s n n n n s s n n ! s !

must involve preceptor, student, and faculty. Faculty need to determine if the student will drop out, move to a new site, or stay in the environment. If the student is to stay at the site, a specific plan to improve areas of concern must be developed. The plan may include more closely supervised time in faculty practice site, time observing role models, or extension of time in clinical setting (depending on school policies). The student must be willing to make the commitment and effort to address the areas of identified concern. Finally, time for follow-up evaluation and criteria that all agree to must be set (Table 3).

**Evaluation**

While implementing a corrective plan, the preceptor needs to reassess the student at each clinical experience, determine if the student is making progress in the identified areas with the intensified input, and document each visit with short but specific descriptors about specified skills and progress or lack of it. The preceptor should let the student know where progress has been made as well as areas that need continued work, and must continue to use faculty as collaborators.

When the diagnosis is specific and interventions are aimed at the

particular needs of the student, the most common outcome is improved performance. If improvement occurs and is satisfactory, faculty will need to determine what strategies need to continue for improvement in the next clinical. However, if performance continues to be unacceptable with outcomes not demonstrated in the time frame agreed upon, a recommendation for withdrawal from the clinical rotation or the program may be appropriate. Skillful academic counseling can often achieve this outcome in a way that provides the student with other career options. Faculty greatly appreciate preceptors for sensitive and useful assistance with diagnosis of failures of the student's performance to match the expectations of NP course and, ultimately, the NP role.

**Learning Disabilities**

It is not unusual for the demands of graduate education to uncover a learning disability that the student has been able to compensate for in previous education or professional practice. If the assessment process leads the preceptor and faculty to suspect a learning disability, referral to the university's Office for Students with Disabilities is recommended. Professionals can assess the stu-

dent and, if necessary, refer the student for more in-depth assistance to identify the accommodations needed for the student's success. In addition, the Office for Students with Disabilities can provide counseling, coaching on effective strategies for learning, and advocacy for needed accommodations. Generally, if the student has a documented learning disability, accommodations are mandated by law. A student's or faculty's belief that a learning disability exists is not sufficient for accommodation. Documentation of a learning disability by a professional in this field is crucial for the student to have any "legal" right for accommodations. Preceptors who suspect a learning disability need to convey that information to faculty who, in turn, will work closely with appropriate academic units.

**CONCLUSION**

In conclusion, with appropriate expectations and some strategies for basic teaching with adaptations for special student and clinic needs, most practicing NPs can function as excellent preceptors. Preceptors are urgently needed to prepare the next generation of clinicians and to provide the access to patients so important to clinical learning. In turn, preceptors obtain satisfaction from meeting a professional obligation.

The great majority usually find teaching enjoyable, and they learn from the students. There is no "secret recipe" for successful precepting in a busy environment except the following: find the appropriate place, provide adequate light, nurture, protect and give time to grow! Being a preceptor is a rewarding activity. If the NP role is to continue, the best and brightest clinicians need to be involved with education of their future peers, and they will find the preceptor role enriching!

## REFERENCES

- Abel, E., Thelen, A., & Irwin, D. (2004). *Essentials of the On-Minor Preceptor Role in the Family Practice Setting*. *Journal of Family Practice*, 7, 42-49.
- Ahlman-Lindholm, C. (2000). *Teaching in the Family Practice Setting*. *Journal of Family Practice*, 5, 111-118.
- Baker, M., & Hirsch, E. (1996). *Assessing the Family Practice Preceptor Role*. *Journal of Family Practice*, 21, 155-159.
- Bennett, P. (1984). *Family Practice: A Case Study*. *Journal of Family Practice*, 30, 549-550.
- Brown, C. (2003). *Preceptor Role in the Family Practice Setting*. *Journal of Family Practice*, 52, 50-55.
- Carroll, C. (1989). *Essentials of Family Practice*. *Journal of Family Practice*, 1, 44-48.
- DeRubeis, D., Dornan, G., Szymanski, J., Finkbeiner, G., Benin, J., & Stein, D. (1997). *Assessing the Family Practice Preceptor Role*. *Journal of Family Practice*, 72, 358-361.
- DeRubeis, M., Szymanski, K., & Dornan, M. (1993). *Teaching in the Family Practice Setting*. *Journal of Family Practice*, 5, 27-33.
- Fisher, V., Fisher, K., Granger, S., VandeMee, M., Fisher, E., Rabin, M., et al. (2001). *Preceptor Role in the Family Practice Setting*. *Journal of Family Practice*, 1, 71.
- Fisher, S.A., Dornan, E.C., & Kohn, S.K. (2000). *Family Practice Preceptor Role*. *Journal of Family Practice*, 12, 3-10.
- Gardner, T. (2000). *Family Practice Preceptor Role*. *Journal of Family Practice*, 12, 3-10.
- Hirsch, E. (1994). *Family Practice Preceptor Role*. *Journal of Family Practice*, 1, 62-66.
- Hirsch, E. (1998). *Family Practice Preceptor Role*. *Journal of Family Practice*, 10, 53-57.
- Hirsch, E.F. (2001). *Family Practice Preceptor Role*. *Journal of Family Practice*, 5, 175-180.
- Irwin, D. (1995). *Family Practice Preceptor Role*. *Journal of Family Practice*, 70, 898-909.
- Irwin, D., Abel, E., & Thelen, A. (2004). *Family Practice Preceptor Role*. *Journal of Family Practice*, 7, 50-55.
- Kohn, N., & Stein, Y. (2000). *Family Practice Preceptor Role*. *Journal of Family Practice*, 20, 218-226.
- Knapp, M. (1984). *Family Practice Preceptor Role*. *Journal of Family Practice*, 30, 549-550.
- Lindholm, J.E., & Rabin, N. (1997). *Family Practice Preceptor Role*. *Journal of Family Practice*, 11, 101-109.
- Lindholm, D.E., & Pappas, J. (2001). *Family Practice Preceptor Role*. *Journal of Family Practice*, 13, 237-240.
- Mohr, C., & Miller, F. (2003). *Family Practice Preceptor Role*. *Journal of Family Practice*, 43, 188-96.
- Morgan, S., & Irwin, D. (1997). *Family Practice Preceptor Role*. *Journal of Family Practice*, 12, 34-40.
- Morgan, M., Szymanski-Granger, P., Bennett, P., 175-