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) *20*, 172-183.

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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

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 *detective* in taking a thorough and focused history, *reflective* about the information gathered from the history and physical and ultimately *effective* 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 setting with a wealth of previous nursing experiences, whereas others may come from a non-nursing background with other unique experiences to enrich their nursing practice. Regardless of the type of their past experiences, adult learners are interested in sharing their history and merging their past lives into their new roles as NPs (Nebraska Institute for the Study of Adult Literacy, 2005). It is important to consider previous experience in the planning of clinical opportunities. Activities should include new experiences, such as care of older children for the former NICU nurse, as well as application of previous skills to new situations to help students integrate important aspects of their previous lives into their NP training.

Adult learners are often experiential learners who prefer to take an active part in the learning process rather than being passive recipients of information. Ideally, NPs view learning as a problem-solving activity rather than just an information-gathering activity. This problem-solving focus is significant in the development of es-

Table 1. Role expectations and pressures

Student	Faculty	Preceptor
Role expectations		
Arrange schedule Develop personal learning objectives Address course objectives Observe policies and procedures of agency Confer with preceptor and faculty about progress and problems Prepare for each clinical day Review and read about past day's work Evaluate faculty, course, and preceptor	Identify and secure appropriate sites for students Prepare student with necessary clinical skills Provide preceptor with course objectives Visit site during student experience Support and help preceptor develop teaching skills Monitor and evaluate student progress Provide evaluation feedback to preceptor Solve student and/or preceptor problems with the rotation Guide student clinical learning through class, chart reviews, case studies, assignments Provide feedback to student Teach clinical reasoning and skills from own knowledge and experience	Orient student to site, policies, procedures Facilitate informal, collaborative, respectful learning environment Be a positive and effective role model Provide learning experiences with appropriate patients Provide on-going feedback Pace learning experiences to meet student needs Direct student to resources, readings Notify faculty of concerns about student's behavior, work, or progression Provide evaluation data to preceptor
Role pressures: potential areas of difficulty		
Make connections between didactic and clinical work Work according to prescribed trajectory for clinical progress Balance adult life with student expectations Achieve learning needs within a service environment	Identify preceptors and appropriate settings that meet student learning needs in a time of preceptor shortage Evaluate student progress indirectly through written documentation and short visits to the site Keep learning expectations from impacting too greatly on preceptor service demands Orient and develop preceptors within their time and interest constraints Reward preceptors for their work	Teach from experience base Maintain patient care service expectations Fit clinical teaching into the program's curriculum Maintain rapport with patients and families while involving student in a meaningful way Persuade colleagues to assist with student education Convince administration to permit students at site

sential 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

Preparation and planning. 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.

Teaching strategy options. 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. *Observation* and modeling 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 presentations 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 (Corralli, 1989; Wolpaw, Wolpaw, & Papp, 2003).

Direct 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 questioning methods are discussed in the literature. An especially useful approach to teaching when time is very short is the "One Minute Preceptor Method" described by Neher, Gordon, Meyer, and Stevens (1992) and evaluated for effectiveness in several studies (Aagaard, Teherani, & Irby 2004; Irby, Aagaard, & Teherani, 2004). This strategy requires the preceptor to get a commitment from the student about what the student thinks is going on after seeing a particular patient. The preceptor then challenges the student to provide supporting evidence for the assessment. This enables the student to draw from previous clinical experiences, as well as coursework and readings. The preceptor gives immediate feedback to the student about what was correct about the assessment and helps the student recognize some general rules that applied in the specific situation (Table 2).

The "Think Aloud Method" (Lee & Ryan-Wenger, 1997) requires the student to provide a rationale for specific questions that were asked and physical examination techniques used to show how conclusions were reached. This approach fosters critical thinking and clinical reasoning skills. It is useful with all levels of learners but especially for the beginning student, because it requires the student to verbalize thoughts and support decisions. For example, the preceptor will

Table 2. The One-Minute Preceptor Technique

Learning goal	Script	Rationale
1. The student is to make a decision regarding the case at hand	"What do you think?"	This question is helpful throughout the decision-making analysis—from making a diagnosis to working out a plan; the student is not simply providing information to the preceptor to make decisions
2. Probe for supportive findings and evaluate the critical thinking that led to the decision	"Why do you think that?" "What led you to that conclusion?" or "What else did you consider and rule out?"	Diagnose the learner's understanding—gaps and misunderstandings, poor reasoning or attitudes; do not ask for textbook knowledge
3. Tell student what was right in the conclusions and critical thinking	"Specifically, you did a good job of ________ . . . and this is why it is important. . . ."	State specifically what was done well and why it was important to reinforce excellent performance
4. Correct student errors	"You did well based on your knowledge of older children but didn't factor in the infant's development"; "I disagree with . . ." ; "A more efficient way. . ."	Specific correction will reinforce correct ideas and extinguish incorrect ones
5. Teach a general principle/ clarify the take-home lesson	"The key point I want you to remember is . . . ."	Point out key ideas, prioritize essential points among many details
6. Your own one-minute reflection	"What did I learn about my teaching?", "What did we learn from this?"	Place exercise into larger context of patient care and refocus for teaching episodes

Adapted from Neher, Gordon, Meyer, & Stevens, 1991.

ask, "Why did you ask about fever?" This approach works well in clinical seminars conducted by faculty.

Assigning directed readings on specific clinical topics that arise during visits is helpful. The literature reinforces general rules and fosters the development of conceptual frameworks. Directed readings are especially important for beginners because they may not have enough experience to determine where to find the best information in the nursing or medical literature. The preceptor suggests readings and asks for a brief report at the next session.

Coaching is another excellent teaching method. In this process, the preceptor provides verbal cues to the student as he or she moves through a procedure. The intent is to keep the student safe and efficient while mastering the steps of a skill that may not yet be automatic in nature.

Feedback from preceptors is critically important, especially with adult students whose learning is enhanced if they believe they are making progress (McGee & Irby, 1997). Effective feedback is descriptive of specific situations and skills and is given soon after the preceptor's observation of these concrete events. It reinforces what has been done correctly, reviews what needs to be improved, and corrects mistakes. Feedback is less judgmental than evaluation and is best given informally throughout the student's experience. Feedback is sometimes more meaningful if the student has the opportunity to do a self-assessment prior to hearing the preceptor's comments. For example, a conversation regarding the question, "How well do you think you addressed this mother's concerns?" will give the student the chance to share his or her rationale for the approach while also prompting the further discussion about the question, "How could you have done this differently?"

Evaluation. Evaluation is an important component of the preceptor/NP student relationship. The preceptor needs to be familiar with the university curriculum, the university's goals and objectives for the specific clinical experience, and the evaluation tool that is required by the school at the conclusion of the placement. Having a good sense of what knowledge base the student is expected to have will be helpful. In addition to the expectations of the university and the preceptor, it is helpful to address the student's personal goals for the clinical experience. Realistic goals are best met if they are written down and discussed early in the experience as well as periodically throughout the rotation. An evaluation session midway through the term and at the end of the rotation is essential. The student should be encouraged to self-evaluate as well as to receive evaluative information from the preceptor. Of course, the preceptor's evaluation also needs to be

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).

The beginner. Beginning or advanced beginner students typically 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.

The transitional learner. 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 stretched to a new level. Case presentations, the "think aloud" method, and assigned readings continue to be effective strategies for transitional students.

The competent proficient learner. The final type of student learner is the competent proficient learner. This student has solid skills in history taking, physical assessment, evaluation, and management, as well as increased clinical judgment and the ability to relate past clinical situations to current situations (Davis et al., 1993). This student is more flexible in thinking about cases because he or she has previous experience to draw upon and is more time efficient and comfortable with the advanced practice role. Thompson et al. (2001) describe this stage as one in which the preceptor can "step out." Competent proficient students, like all experienced clinicians, are aware of their limitations and still ask questions and seek the input of clinicians with more knowledge. The focus of precepting a competent proficient learner is on pattern development and the use of schemata or general representations, seeing which can be applied across patients. Competent/proficient students should see more medically and socially complex patients within designated time frames.

As the student nears the end of later clinical rotations, it is important for the preceptor to know when it is time to let go and allow

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 & Yonge, 2001). Frequently expressed barriers to being an effective preceptor and a clinician at the same time include the following: feeling overworked, being unprepared for teaching, being mismatched with students, lacking adequate time, and receiving insufficient feedback and guidance (Hayes, 2001; Yonge et al, 2002). Avoiding as many pitfalls as possible is important for both preceptor and student.

Preparing for the Day

To be successful on a busy day, it is essential to do good pre-planning. Preparation of the clinic setting is essential. All members of the practice setting must be aware of the student's arrival and expected length of stay both in terms of daily schedule and length of calendar time to be spent in the setting. Such things as scheduling patients, arranging examination room availability, providing space for charting, and planning for student access to patient records need to be addressed.

It will also help to meet the student for the first time before the first day of the rotation by planning for a brief student interview before the first day begins. Discussion should include a review of the student's goals, learning style, and past experiences. The student can be asked to arrive with a questionnaire including this information and contact information already completed. The preceptor also needs to share some of his or her history and usual teaching style. The preceptor should describe the agency, the types of conditions cared for, and the mission of the agency. Any specific standards or guidelines that the site has in place governing student behavior or NP roles need to be shared at this time. A tour of the site and introduction to staff will help.

Each day of the preceptorship, further planning should occur. Review of the appointment list for the day and identification of appropriate patients for the student to be involved with is a good idea. The preceptor needs to communicate clearly to the student the expectations with regard to numbers and types of patients seen, amount of time available to spend with each patient, and amount of preceptor time available to the student. Clearly delineated expectations help the student perform as optimally as possible while not compromising the care of patients. Explaining where the difficulties lie and where the learning opportunities will likely appear is essential.

The expert preceptor is constantly doing "invisible planning"—thinking ahead about other activities that will be helpful to the student's progress (Skeff, Bowen, & Irby, 1997).

Students want to be helpful and involved in clinic work. They also are using the preceptor as a role model to see how clinicians problem-solve clinic management issues. Focus on the student by stating such plans as, "We will review the cases for the morning over lunch," or "Keep a 3 × 5 card for questions you have during the day and we will address them for 20 minutes at the end of the day or when we have a break in the schedule."

Use of Other Resources

Thinking broadly about the student's education is useful. Preceptors often feel guilty about using others' expertise and resources in the practice setting (Kaviani & Still-

BOX 1. Tips for teaching on busy days

Pre-planning

1. Prior to the clinical experience, describe to the student the pressures you face.
2. Get to know your student's learning style and needs before the first day of patients.
3. Review the cases for the day with the student and mutually decide where the best learning opportunities are likely to arise.
4. Have some other ideas in mind for times when you cannot teach for one reason or another. For example, student can listen in on triage phone calls, follow-up by phone with cases seen previously, go with another provider who likes to teach, spend time with the laboratory technician or pharmacist, or use the Internet to answer a question that had been unanswered from a previous discussion.
5. Set priorities for the student to accomplish and activities to complete by the end of the day.

Student time with patients

1. Work together with one patient to decrease the time spent and allow the student to see your assessment and care for efficiency. Have student do the history, and then you do the physical. Rotate tasks for the next patient.
2. Help the student recognize what to include in a focused history and examination for the presenting concern without going onto contextual or tangential issues.
3. Assign the student to patients whom you know like extra time.
4. Set a time limit on the student: "Get as much of the history as you can in 10 minutes and I will come in."
5. Schedule your patients in waves: two in time slot 1, one in time slot 2, and none in time slot 3. In the first time slot, you and the student start out in different rooms at the same time. You do a second case in time slot 2 while the student finishes his or her case and prepares to discuss it with you. Use the break in time slot 3 for completion of the student's case, charting, and preparation for the next wave. You will have kept your productivity numbers at three cases in three time slots.
6. Go into the patient's examination room with the student and chart the history and physical while the data are being collected by the student. Then reverse roles and have the student document while you gather the data.

Case presentation time

1. Set a limit on length of presentation time. "Tell me the H & P, diagnosis and your plan in 5 minutes."
2. Ask the student to present while both of you are in the room with the patient. (Be careful if there is psychosocial information or other factors that should be communicated and discussed privately between you and the student first.)
3. Assign the student to patients you know well, as this may speed evaluation of accuracy of student data. Also, give the student background on the patient to help focus the history more efficiently.

Finding discussion time

1. Ask the student to keep a file card handy to write down questions for discussion later. Follow up daily for 15 to 20 minutes.
2. Use travel time to and from clinic or to lunch to discuss cases.
3. Set limits on time for encounters. "I can meet with you for 10 minutes now. You can have 5 minutes to ask me questions and then I want to give you some feedback on the patient we saw together this afternoon."
4. Ask the student to look up information on three cases you saw during the day, but make it clear that you will ask for a report the next session on only one of the three cases.
5. Jot down patient care pearls that arise from various sources. Collect them on a list and share with the students.
6. Honor your appointments with students. Keep them brief but focused.
7. Expose students to the complete day. Take them to noon conferences, committee activities, and civic activities.

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 system with a colleague to share students occasionally. Teaching also can involve use of online resources and exercises. Perhaps there is another clinician who has something special scheduled for the day. Would a morning with a laboratory technician be helpful? What about a couple of hours with the nurse doing telephone triage or follow-up? Would it be informative for the student to call some patients to evaluate care given earlier? Creative ways of assessment and evaluation of learning in addition to direct observation will be helpful, particularly if planned for efficient use of time (DaRosa et al., 1997).

Trimming Time off Teaching Activities

Listed in Box 1 are some strategies that can be adopted for teaching on busy days. They relate to pre-planning, student time with patients, case presentation time, and finding discussion time.

A scheduling strategy that might work in some practices but not others, at least formally, is to schedule patients in waves—two in slot 1, one in slot 2, and none in slot 3. That will let the preceptor and student each start off with a

patient to see (slot 1). The preceptor can continue with the third case in slot two while the student finishes his or her case. The break in slot 3 will give time for teaching before the next round begins. In terms of the whole day, three patients will have been cared for in each three time slots. Whether formally scheduled or not, the principle holds as a way to carve out teaching time in the midst of the clinic work.

It is essential that preceptors be realistic about the amount they attempt to teach. Small bits are fine. It is also essential to give feedback daily, keeping it short and directed at the care given that day. Vary teaching strategies depending on time, student need, and level and clinical opportunities.

Evaluating the Teaching Day

Evaluation of the teaching day should occur routinely. One particular example may be called the "End of Day Newspaper Review" technique. Thinking briefly about who was seen, what got done, how the student felt about it, where the student wants to go next, and why things worked or did not can be very helpful when done on a routine basis.

Every preceptor needs some fundamental skills, what may be termed "preceptor know-how." A skilled preceptor knows how to navigate the clinical system, knows how to create a climate for learning, and knows how to get the expected work done (Mamchur & Myrick, 2003; Myrick & Yonge, 2002). Role modeling, guiding, facilitating, and prioritizing are key concepts for the busy preceptor to keep in mind. Strong organizational skills and the ability to set priorities may be critical factors in success for precepting in a busy setting. Morrow (1984) has clearly delineated the priority setting process. A good prioritizer carefully identifies the activities that are important, essential, time sensitive, urgent, and/or must be completed on time. Distinguishing between the activities that must be accomplished today versus those that would be nice to do is an essential skill.

WORKING WITH THE DIFFICULT STUDENT

Although the preceptorship is a positive experience for all parties the majority of the time, problems occasionally arise. Skilled preceptors often can turn difficulties around, or at least will take appropriate steps to resolve issues. Generally, this difficulty is related to student performance, but occasionally the issue is one of student dissatisfaction or poor communication, perhaps from lack of a good match between the student learning style and preceptor style or characteristics of the clinic. A "difficult student" may be frustrated, anxious, bored, overwhelmed, unprepared, distracted, ill, or otherwise having some difficulties.

Preceptors, faculty members, and students all need to be involved with resolution of student performance problems in the clinical setting. The preceptor's first resource is a close working relationship with the program faculty, and preceptors should not hesitate to ask for a "diagnostic visit" by program faculty. Some preceptors, especially inexperienced preceptors, are tempted to wait, sometimes for extended periods, thinking a difficult situation will "get better."

Communication with faculty is enhanced by a comprehensive assessment of factors that seem to contribute to the student's lack of performance. However, even if preceptors are not able to pinpoint specific factors, they should not hesitate to send up a "red flag" to program faculty. Serious problems should be addressed that very day with a call to faculty. Notes should be made regarding the situation of concern with dates and specifics, so that the faculty can be as well informed as possible when contacted.

Even when a potential problem seems to be emerging, the preceptor should maintain quality teaching. Opportunities for learning and application of knowledge should be provided. Continue to give the student specific rather than general feedback, share information rather than give advice, and, above all, keep communication open (Benzie, 1998). A key concept to keep in mind is that focusing on behaviors that can be changed rather than personality traits is the best strategy.

Diagnosing the Learning and Performance Issues

The diagnosis of clinical learning problems needs to include data about the setting and specific cases, the student's behavior, preceptor efforts and responses by the student, and the student's perceptions of the situation, all in light of course expectations. Data should include both the student's strengths and deficits. The preceptor should expect that the student (a) is prepared each day, (b) demonstrates history-taking skills appropriate for the situations at hand, (c) demonstrates critical thinking in data collection, (d) uses good physical examination skills to gather appropriate additional data, (e) demonstrates health promotion knowledge and management skills, and (f) uses knowledge of acute illness management to correctly make diagnoses and identify treatment options at a level appropriate to the course and curriculum. A student should also be able to maintain a reasonably organized approach to patient care and use of learning opportunities. Communication with staff, preceptor, and patients should be clear, organized, and appropriate. This also applies to written documentation and oral presentations of cases. Usually these elements will be consistent with clinical course objectives for NP courses. Examples of problems the preceptor may see include inability to take initiative

BOX 2. Indicators that the student is learning in the clinical setting

Behaviors that indicate the student is "getting it"

- Presents thorough, focused history and physical
- Consistently articulates sound decision making
- Develops and implements reasonable plan
- Connects with patient interpersonally in caring manner
- Is organized, independent, time-efficient
- Is self-confident but knows limits; asks for help
- Has holistic view of care; includes health promotion and disease prevention
- Provides concise charting and oral presentations

"Red flag" behaviors

- Is hesitant, anxious, defensive, not collegial
- Has uneasy rapport with patient and misses cues
- Presents less focused history and physical with excessive incomplete data
- Performs physical examination poorly, inconsistently
- Is unable to explain reasoning for diagnosis
- Is unable to prioritize patient problems
- Is unable to create plans independently
- Misses health education and disease prevention opportunities in plan
- Is unsure of tests to order
- Is unable to provide clear charting and presentations

Adapted from Ahern-Lehman, 2000.

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, 1998). Faculty and preceptor will need to discuss whether adequate adaptations can be made to achieve a fit for the student.

The level of performance should be specified through course objectives and an understanding of the course placement in the curriculum (e.g., a last-term course should have expectations approaching the new graduate's level of functioning). Preceptors may find it useful to document the behaviors identified by Ahern-Lehman (2000) as exemplars that students "get it" or behaviors that are "red flags" (see Box 2). Faculty absolutely need these data.

As a part of the student assessment, the faculty needs to determine if there are other issues from the student's perspective, including competing demands. The preceptor can provide helpful input to faculty from information provided by the student. Faculty will need to decide if the student has competing life crises and whether the student can realistically put the necessary effort toward clinical learning to meet course objectives. It is important that the preceptor not confuse the preceptor role with that of counselor. If assessment reveals mental health problems, faculty will refer the student to appropriate mental health services. In any case, even if the student is under unusual stress or going through a difficult time, the student is disadvantaged if preceptors and faculty do not have clear expectations for acceptable performance. Additionally, having an impaired student in the clinical setting can be extremely frustrating or even dangerous.

Additional Diagnostic Activities

If the preceptor's primary site is not optimal for evaluation of the student having trouble, several options may exist. Many programs have senior preceptor or faculty practice sites to use to diagnose student performance. In addition, some program faculty use laboratory simulations for diagnostic assessment. A simulation is conducted in a less intense environment and is accompanied by extensive analysis and debriefing, which can be helpful in assisting struggling students.

Implementing a Corrective Plan

If a "match" or "fit" problem is ruled out and a student problem is identified, a corrective plan needs to be developed by the preceptor/faculty team, a time frame set for corrective action, and an evaluation plan developed to determine if change has occurred. The plan

TABLE 3. Examples of interventions for problematic performance

Problematic performance examples	Interventions
Unorganized or incompetent history	If the student is not competent, determine if she or he has an organizational framework for history; if the student lacks a useful framework, re-orient to presentation basics (Coralli, 1989)
Lacks effective presentation skills	Encourage timing of verbal presentations and convey the expectation of extensive practice outside the clinical setting; effective strategies include rehearsal and use of a tape recorder; faculty may select and evaluate select taped presentations
Difficulty applying concepts covered in educational program	Give student responsibility to be prepared for one system (or specific problem) and a specific well-client visit for each clinical experience; ask student to outline the priority concerns, assessments, and decision points in a concise, articulate, and clinical relevant presentation in less than 4 minutes
Persistent difficulty "grasping" organization of problem-oriented chart and generating charting with logical flow	Refer to Office for Students with Disabilities for evaluation of possible learning disability

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 to 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 student 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!

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