

The Death of Altruism, or, Can I Get a Preceptor, Please?



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If you ask most physicians, PAs, and NPs why they decided to pursue a career in health care, the clichéd and somewhat unwavering response usually includes some variation of “I want to help people.” Although this view is extolled and encouraged, today’s complicated (and at times competitive) practice of medicine has a way of robbing us of that altruism.

What prompted these musings? The other day, the PA program at our university received a letter from a physician group that, for years, has provided us with quality preceptors for our students. The gist of the letter was to inform us that they could no longer take our PA students, because the time spent precepting resulted in reduced productivity and the compensation offered was not enough to offset that loss.

Now, don’t get me wrong, I understand. In today’s “corporate” mentality, productivity makes or breaks a practice. But we have also seen the number of PAs, NPs, and physicians—including alumni of our program—who offer themselves as preceptors dwindle.

Why is this happening, and what can we do about it? With more than 200 PA and 350 NP programs (and counting), the pressure to find and maintain clinical rotation sites and preceptors for thousands of PA and NP students will continue to increase.

We might first consider critical aspects of our “contract” with society—the one that defines our professionalism. Once we take that

oath (whether the Hippocratic or another developed by and for our professions), we vow to put patient welfare first. In return for your service to patients, your contribution to the public good, and your assurance of competence and a high level of morality, integrity, accountability, transparency, and objective advice ... you will be conferred very significant privileges as a PA or an NP. Those privileges include trust, self-regulation, participation in public policy, funding for what we value in both patient care and medical research, and many personal rewards.

However, there is one other stipulation: The social contract calls for altruistic service. But altruism specifies that one’s deeds benefit the recipient and not necessarily one’s self. The word *altruism* is derived from Latin through French and refers to “the good of others as the end of moral action.” Auguste Comte, a French philosopher, coined the term. He believed that individuals had a moral obligation to reject self-interest and live for others.¹

I am not sure that is possible in today’s society. Can you “altruistically” relinquish your personal interests, your autonomy, and the primary reason for your existence—life, liberty, and the pursuit of happiness? My answer is maybe not. On the other hand, *selfishness* becomes a virtue when your own happiness is tied to service.

But enough philosophizing. What does this mean for us? A preceptor is one “who teaches,

counsels, inspires, serves as a role model, and supports the growth and development of an individual (the novice) for a fixed and limited amount of time, with the specific purpose of socializing the novice into a new role.”² A preceptor fills three primary roles: nurturer, educator, and mentor. He or she guides and enhances the learning experience of students by providing ideas, information, resources, and feedback.

I would argue that altruism is as important in giving back to our professions as is quality patient care. Think back to your student days (which may be a ways back for some of us). Remember anxiously entering the clinic or hospital on your first day and nervously approaching the front desk to ask for your assigned preceptor, who would play a key role in your transition?

All new professionals acclimate themselves with guidance from preceptors. We all have favorite preceptors and cherished experiences. Our preceptors were dedicated to our success and gladly gave of their time for the betterment of the profession. I am fearful that today’s preceptors do not have the same dedication to students. But please, tell me I am wrong!

In fairness, I do think there are multifactorial barriers facing today’s preceptors. Discussion of this issue with colleagues produced the following reasons for the changes we’ve seen:

Preceptor skill level. As educators, we may have failed in our efforts to teach our preceptors how to mentor or precept. Some may not be confident enough in their own skills to be able to precept—or perhaps they are just indifferent.

Time and resources. Time and reimbursement are factors in almost every aspect of health care nowadays. It’s just not possible to say “yes” as often as we used to; the pressure to see patients and maintain or bolster the bottom line is immense. It may be that younger generations of clinicians would be willing to precept, if not for the difficulties associated with reimbursement and lack of time.

Income is now often based on production: the more you see, the more you are paid. With the complexities of ICD-10, the documentation process is much more com-

plex and/or tuition to the student.

There is also the issue of who gets the compensation—the institution or the preceptor—which causes some angst among preceptors. Some clinical departments or institutions are paid a lump sum to allow for released time for the provider; others allow the provider to be compensated directly.³ One group I am aware of decided to split the compensation evenly, as they felt this would be the most equitable solution.

Lastly, the amount of compensation varies. This can create a competitive atmosphere as pro-

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plex. And then there’s the need to document everything thoroughly in the hopes of allaying litigation somewhere down the road. And so on ... What it comes down to is that if the preceptor is unable to see the required number of patients because of time spent precepting a student, many administrators will not support the concept of “giving back.”

Financial compensation for precepting. Paying preceptors is now the norm rather than the exception. The time and effort spent is certainly worth compensation, but with decreasing education dollars, the overall quality of PA and NP education could suffer. Tuition is already high and, whether we like it or not, the cost of paying preceptors will eventually roll over into increased fees

grams “bid” against one another to secure precepting services.

Student preparation. Taking on students is a sacrifice, and the preceptor rightfully should expect them to be ready and willing to learn. At times, there is lack of preparation on the part of the student to be ready to dive in and see patients and not take all day!

But a bigger issue, I think, is that we don’t seem to instill in the new generations of professionals the responsibility to give back to our professions. So many barriers to our professions have been mitigated—we have recognition, reimbursement, and prescriptive authority, as well as the respect of our colleagues—that today’s students don’t have the “fights to fight” that we did. I think that contributes to the decreased dedica-

tion (beyond that to the patients, that is). Maybe too, we viewed our choice of profession as a calling—a vocation in which you have to give back to those who come after you—whereas many people today see it as just a job.

Practice is too specialized. More and more PAs and NPs practice in specialties (and some

ter those relationships and bring back the altruism needed to precept in today's society:

- Seek nonfinancial incentives for preceptors, such as Category 1 CE/CME credit, discounts for conference attendance, opportunities for academic advancement (eg, adjunct clinical professor sta-

“An NP colleague recently took a ‘student vacation’ because, in her opinion, many of the students she had precepted were not well prepared, academically or otherwise.”

in subspecialties). This means they may not be equipped to offer the generalist or basic specialty clinical education required by the program.

So, yes, the decline of altruism may be a sign of our changing times. But nonetheless, we need to prepare our NP and PA students to step into real-world roles and provide quality patient care. We must identify solutions to this problem, because we cannot simply “drop” precepting or clinical rotations. So what can we do?

Many PA and NP programs have worked hard to develop relationships with preceptors and institutions that support the process. Here are some ways to fos-

ter), and access to resources via the university library.

- Advocate for a state Preceptor Tax Incentive Program (such as the one in the state of Georgia).
- Reduce the (often copious) amount of paperwork that educational institutions require of preceptors.

We also need to ensure that our students are adequately prepared. In the past decade, students enter our programs with high expectations of what they will get out of a clinical rotation and a preceptor. Some may lack a touch of humility or a servant's mind, both of which are important to their success.

An NP colleague recently decided to take a “student vacation” for six months, as her opinion was that many of the students she had precepted were not well prepared, either academically or in work/life experience. Her assessment of increasing class sizes was that some students are there “just to fill the program up” and make it profitable. To my colleague's way of thinking, there is a disservice being done to students who are on rotations and not ready for them. We need to make sure our students are prepared to face the challenges of clinical rotations.

We also need to encourage a renewed sense of altruism in our students, so that they feel compelled to precept when they are alumni. So how do we enhance our preparation of future clinicians through precepting? I would love to hear from you about barriers you have encountered—and preferably, some viable solutions! You can reach me at PAEditor@frontlinemedcom.com. **CR**

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