

# Precepting: Holding Students *and* Programs Accountable



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**R**andy Danielsen's editorial on the topic of precepting (April 2016) elicited a flurry of responses from our NP readers.<sup>1</sup> The influx of feedback prompted me as an educator, an NP, and a former preceptor to wonder: Why the paucity of preceptors? Are there too many programs and too many students? And are we dropping the ball when it comes to engendering professional responsibility as a "social contract"?<sup>1</sup>

Let me start with a query: Are we requiring students to uphold their social contracts? That is, are they engaged in professional networking to enrich their own clinical experiences? Are they responsible for establishing relationships with providers in their communities in preparation for clinical rotations? Aren't these all components of their social contracts as students?

*“Increasing the number of available preceptors requires overcoming perceived barriers.”*

In my PNP program, we found our own preceptors (there were no clinical coordinators “back in the day”). As a component of that, we often had to educate our preceptors on the role of the NP. Thankfully, the pediatric community was aware of the NP; in the

Boston area, at least, many settings already had NPs (and PAs) as providers. Still, when I reflect back, the experience of finding a preceptor augmented my professional education. It also instilled in me responsibility for my own professional development.

When it was my turn, I agreed to precept as my contribution to the profession. However, my first foray into precepting was not a pleasant one. As some of our email authors attested to experiencing, my student was completely unprepared for her clinical rotation. I found myself teaching basic assessment skills (to a student in her final semester!), which takes considerable time in the office setting. Subsequently, I required students to have at least three years of RN experience and demonstrate a full H&P prior to acceptance. This proviso raised some eyebrows among my colleagues, but as I saw it, my role as a preceptor was to help students to improve their skills—*not* teach them the basics. The result: a happy preceptor and long-standing relationships with the precepted students.

Even so, like many of the clinicians who responded to Dr. Danielsen's editorial, I must admit I eventually stopped precepting. My decision was based on several factors, but the primary reason was that the students and faculty recruiting me were somewhat cavalier in their responsibility for

*continued on page 16 >>*

>> *continued from page 11*

preparedness to practice.

Among the readers who shared their precepting experiences, many cited inexperience in the RN role as a significant issue, as well as the rapidity with which students progress through their NP programs. Some commented that there is too much material to understand and process and not enough time to master the skills. These observations lead me back to the idea of “too many programs and students.” I know I risk offending my colleagues in academia with that statement. But I also know, from conversations with colleagues and the volume of emails we received on this topic, that many preceptors are frustrated by some students’ lack of responsibility, motivation, and preparation for their clinical rotations.

“*Precepting is a partnership between the skilled practitioner, the NP faculty, and the focused student.*”

Some chalk up this shortcoming to being “millennials.” Others suggest that online programs do not hold students accountable for the “real world” demands of the job. On the latter point, I would submit that the “brick and mortar” programs have similar issues with students. And while both of these points have some validity, I think the problem is more complicated.

We face a perfect storm in NP education: The demand for NPs has increased as a result of the implementation of the ACA. In response to this demand, the number of NP programs has grown, and so has the need for NP preceptors.

Yet, at this critical time, the number of preceptors is dwindling (in volume, yes, but also in willingness).

To resolve this conundrum, we must take a closer look at ways we can reverse the declining interest in preceptorship. Increasing the number of available preceptors requires overcoming perceived barriers. One of these, as noted by Barker and Pittman, is the detrimental effect precepting has on productivity.<sup>2</sup> To illustrate this, they presented findings from a study of community physicians that documented an increase in the time taken to see patients and a decrease in the number of patients seen when the physician was precepting students.<sup>3</sup> Additional time and reduced productivity are not tolerated in today’s work environment, and patients,

who increasingly see themselves as health care *consumers* (who can take their “business” elsewhere), don’t appreciate waiting to see their health care provider when they have an appointment.

In their research, Logan, Kovacs, and Barry also found that productivity expectations (or should I say, the expectation of reduced productivity) impeded willingness to precept.<sup>4</sup> They identified lack of time in the workday as a major barrier. This point is difficult to counter, I admit. But they also presented two other deterrents that, conversely, I view as potential opportunities for increasing the number of willing preceptors:

**Lack of training for preceptors.** Preceptors must learn how to fulfill this role on their own, without any training or support. This is a significant problem, not only for nascent preceptors but also for seasoned ones, who often precept students from different programs with a variety of requirements and expectations (and paperwork!). In an editorial, a new preceptor expressed concern about her ability to “get it right” and give her student what was needed to accomplish the goals for the rotation.<sup>5</sup> Training and supportive testimonies are essential for successful precepting. A simple approach would be for program faculty to “mentor” new preceptors: Spend time orienting them to the expectations of the program and explaining how to evaluate students. Be proactive—establish weekly conference calls and share both strategies for successful precepting relationships and the “pitfalls to avoid.”

**Student preparation.** The other problem discussed by Logan, Kovacs, and Barry—and attested to by many of our readers—was the skill level and readiness of students on the first day of their clinical experience. While this responsibility lies with the student (rightfully so), I believe awareness of this problem, and understanding of how it affects practitioners’ willingness to precept, offers an opportunity for our education programs. Students may not know what they don’t know, or some may be too timid to speak up if they feel unprepared to step into a clinical arena (not to confuse that unease with “first-day jitters”). It is incumbent on the program faculty to *ensure* their students—who are repre-

representatives of that program and the faculty—are ready for clinical rotations. What do they need to do? Conduct an assessment of skills and readiness, which would assist all parties—the student, the preceptor, and the faculty—in gauging the progress of skill improvement and student competency and capability as a provider. It is also imperative that any remediation be provided by the program (prior to the student's entrance into the clinical setting) and not the preceptor.

The bottom line is that precepting is a partnership between the skilled practitioner, the NP

faculty, and the focused student.<sup>2</sup> The responsibility for a mutually enjoyable and rewarding experience lies with all parties involved. As seasoned NPs, we must be active participants in preparing the next generation of our colleagues. That is our professional responsibility—our fulfillment of the “social contract.” We owe it to them, we owe it to our patients, and we owe it to ourselves—because someday, down the road, these clinicians will be taking care of us!

When a topic merits two editorials, there is clearly much to discuss. What steps do you suggest we undertake to mitigate this

conundrum? Share your ideas by writing to me at [NPeditor@frontlinemedcom.com](mailto:NPeditor@frontlinemedcom.com). **CR**

## REFERENCES

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