Did Somebody Say "Precepting"?

Rarely have so many people had so much to say about a single topic (at least, one that does not involve national politics). But Marie-Eileen Onieal's editorial "Precepting: Holding Students *and* Programs Accountable" (*Clinician Reviews*. 2016;26[7]:11,16-17) struck a nerve with many readers.

BUT FIRST, A WORD ABOUT VAPING …

As advocates for tobacco control, my colleagues and I took great interest in Randy D. Danielsen's editorial, "Vaping: Are Its 'Benefits' a Lot of Hot Air?" (*Clinician Reviews*. 2016;26[6]:15-16). Our practice offers evidence-based cessation treatment for individuals with nicotine addiction through counseling, pharmacotherapy, and the use of nicotine replacement products.

At our center, we often interact with clients who have had multiple quit attempts. Many of our clients state that they have been unsuccessful using an e-cigarette as a smoking cessation strategy. More often than not, they report smoking a cigarette "here and there" along with "vaping," until they eventually relapse to their usual smoking pattern. Some report that they smoke even more than before they tried to quit. We have concerns about how vaping may renormalize the behaviors associated with smoking. Our clients say that when they vape, it reminds them of the "social" aspects of smoking—"being part of a group" and participating in an activity that keeps their hands busy.

Recent literature suggests that curiosity is the primary reason adolescents engage in e-cigarette use. While the newly implemented FDA regulations on e-cigarettes may keep these

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products out of the hands of some adolescents by prohibiting sales to those younger than 18, there is much more to consider. Along with exposure to nicotine, these devices offer a variety of kid-friendly flavorings that make these products attractive to middle and high school youth. Flavorings will not be regulated at this point in time.

According to researchers, this is a major concern. Findings from studies report that when inhaled, certain flavors are more harmful than others. For example, very high—even toxic—levels of benzaldehyde are inhaled by the user when cherry-flavored e-liquid is heated at high temperatures. The chemical diacetyl, a respiratory irritant known to be associated with bronchiolitis obliterans (popcorn lung), is produced by the aerosol vapors from buttered popcorn and certain fruit-flavored e-cigarette liquids.

As public health advocates, we must provide research to the FDA about the health hazards of the flavoring added to e-cigarettes and continue to fight for this regulation. We must support evidence-based tobacco control interventions, such as hard-hitting media campaigns and tobacco excise taxes, and promote access to cessation treatment, smoke-free policies, and statewide funding. Elimination of tobacco products will reduce the public health burden of tobacco-related illness.

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PRECEPTING & E-QUALITY OF CARE

As a woman of the baby-boomer generation, I was raised in an era when feminism was a focus for many. There was a great deal being written and discussed to encourage women to attain equal pay for equal work. Because nursing was (and still is) a profession dominated by women, this was a frequent topic in the classroom. We were repeatedly told, "Don't give away your knowledge for free" and "You deserve to be paid what you're worth, don't discount yourself."

I find it very telling that the same female-dominated academic programs that encouraged me to seek proper payment are now taking advantage of my free labor. I am somewhat offended by this at-

titude and consider it a step backward. Each time NPs are guilted or browbeaten into teaching without proper compensation, the profession is devalued. To continue to participate is to enable a problematic, if not broken, system.

NP education is in need of major reform. The precepting issue is the weak link in becoming a qualified professional who is able to meet the demands and responsibilities that academics and politicos are pushing harder and harder for. Our physician and PA colleagues can rightly argue that their clinical education is superior to ours—and I cannot fault our colleagues for expressing concern about quality of care. If nursing really wants an equal place at the table, this weakness must be improved, or the naysayers will have plenty of evidence that they were correct in the years to come.

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"Each time NPs are guilted ... into teaching without proper compensation, the profession is devalued."

NP SCHOOLS & THEIR RIGID RULES

I have been a preceptor for at least a dozen NP students and have yet to be offered compensation. Preceptors take the place of a paid instructor, giving away free advice and experiences. I don't mind doing this, but at times it can be a struggle. Some students, for example, have never done a pelvic exam. Letting an inexperienced NP student practice a pelvic exam on a patient who made an appointment to see an experienced provider is unjust and unfair to the patient—I won't do it. These schools need to provide practice sessions on paid patients so their students can learn these skills.

I have my beef with the institutes of higher learning, not the students. It feels like a one-way street. You fill out the forms they require in order to precept, which takes up valuable work time. You equip their students with the skills they need to practice safely and correctly, and then try to fill out their evaluation sheets on things that students are not licensed to do.

Schools present their contracts and won't adapt them to match what your employer wants. We are doing them a service, yet they dictate how we do it. My practice no longer takes students from certain schools, simply because we do not agree with their contracts. These poor students are thrown out without a life raft to find their preceptors! Aren't their schools getting paid to do something?

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TEACHING & PRECEPTING: TWO SIDES OF THE SAME COIN

I am a 64-year-old NP who has been precepting in Montana for the past four years. The students I precept are responsible for finding their own preceptors, just as I was 20+ years ago. However, preceptors are hard to find here, as the population is widely scattered; this places an emotional burden on students. They cannot be picky in choosing where they go. Thus, students may not be familiar with the preceptor's practice or ability to teach.

The students I precept are in doctorate programs. My experience has shown that these students have very little understanding of practical application and instead have an overabundance of theoretical knowledge that does not always apply to seeing and treating patients. I believe that this, and the suggested "lack of preparedness," is the fault of the program—not of the student.

Regardless of program faults, students are looking to learn from our experience. Teaching is part of being a preceptor; if you do not want to teach, being a preceptor is not for you. If you want to share your experience and knowledge with those following you (mindful that they may treat you in the future), precepting is an enjoyable experience. But—a good practitioner does not always make a good teacher.

Before becoming a preceptor, you must consider your time constraints, as well as your staff's. You also must consider how your patients will react to seeing a student in your place.

Preceptors need to have a relationship with the student's university apart from signing a paper saying they, the NP, will be the student's preceptor. The university needs to be more proactive, as medical schools are, when finding preceptors willing to take students.

Compensation is another consideration that is rarely mentioned or discussed. Compensation would eliminate some of the negative reactions and might get more preceptors to sign on.

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COLLISION OF CAUSES FOR PRECEPTING HURDLES

I am a family NP practicing in a large internal medicine practice owned by a university-based health care system. I precept NP students because I feel an obligation to my profession. However, the stress and additional workload that precepting places on me will probably lead me to stop sooner than I would like.

The inability to locate enough quality preceptors is a multifaceted issue. Too many students in too many programs, as mentioned in the editorial, is one contributing problem. I have been told by nursing professors that universities profit from their NP programs. They have an incentive to admit a large quantity of students and push them through. We could learn from our MD colleagues, who recognize the value of limiting student numbers.

> *"Teaching is part of being a preceptor; if you do not want to teach, being a preceptor is not for you."*

The rise in NP students has led to a high number of poorly prepared students who enter their programs with no experience as RNs. Preceptors should not teach the basics, and professors should not expect preceptors to do so. Likewise, professors should not expect employers to fill in the gaps for new NPs they hire.

Many NP students have no "real-life" clinical experience to supplement their knowledge and skills. A strong foundation that combines nursing and medical knowledge, clinical experiences, basic assessment skills, and an understanding of human nature and human responses is crucial to being a successful NP. The latter is only developed through experience with patients. Students cannot develop these skills when their professors push them to immediately enroll in NP or DNP programs upon graduation from their BSN or basic non-NP MSN programs.

Our programs would do well to provide all the didactic classroom hours prior to the start of clinical rotations. Thus, the limited clinical hours can be used to hone clinical skills, instead of the current practice of students learning basics while also trying to incorporate knowledge with practice. It is a disservice to our NP students not to have completed classroom learning before starting their limited clinical rotations.

Preceptor overload and "burnout" occurs when very busy NPs are expected to fit precepting into their usual clinical sessions. There are strict mandates that dictate the number of residents a physician can precept. Those rules also allot physicians time reserved just for precepting. Why are NPs expected to precept during their already overworked day? Why haven't our Boards of Nursing and nursing educators demanded this?

Precepting puts us behind during our clinical sessions. In some cases, it can impact our relative value units or patient numbers and salaries. We are teaching on our own time, with no incentives or monetary gain, yet we are expected to devote time and resources to our students.

Most of us do not receive merit-based financial rewards for the extra work. When did it become wrong to expect to be paid for our work? No other profession has this sense of guilt or self-recrimination when asking to be paid for services.

Preceptor training is another issue. Unlike physicians, we are not acculturated in the "see one, do one, teach one" manner. In nursing, we are trained that we must be taught, observed, and tested before being allowed to do anything new. We have a need to be taught everything, including how to precept. That being said, precepting is both an art and a science that involves grasping the basic tenets of learning and mentoring. These are skills that should be taught through observation or in classes so that we can pass on our knowledge. If our NP programs were longer and more step-by-step—in terms of first acquiring knowledge, then incorporating clinical skills with practice—we might learn the skills of teaching and mentoring without feeling we need additional "education" in precepting.

I have been in nursing for more than 40 years and love my profession. There are challenges ahead of us that we can only meet if we are brave enough to look clearly at the way we teach younger nurses, create improved ways of teaching those who will replace us, and actually recognize the value and efforts of those we ask to precept the next generation.

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RAISING THE BAR

I no longer want to be involved in precepting. I, too, find the students to be poorly prepared, and I was flabbergasted when I read a recent post on Facebook—a student offered to pay her preceptor to sign off on her clinicals!

I graduated from an FNP program in 1998 and also felt unprepared at first. My class thought like nurses, in that we expected things to be presented to us. Very few of us were aware that we should prepare *ourselves*, and the program I went through did nothing to inform us of this. It was a rude awakening.

NP programs should have improved since then, but they certainly have not. I have precepted multiple students who did not know how to do a proper physical exam, despite having passed their related courses. I have also precepted students who thought they knew everything and felt I should let them practice solo. Sadly, the majority were simultaneously in both groups.

There is still the stigma that we should remain within a nursing philosophy when we practice, when the reality is that we practice side by side with the doctors. We need to think critically, as they do, and have our programs teach such thinking via competent instructors.

My suggestions include a competency exam for NP instructors so that we can assure a higher, more standardized level of teaching. There should also be a prep course for potential NP students on how to think, including an explanation that it will be *their* responsibility to go after knowledge as well. Finally, we need to stray from the nursing philosophy-type teaching in NP programs and instead focus on stronger clinical knowledge and competence. **CR**

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