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Review

Precepti g 101: Teachi g Strategies a d Tips for Success for Preceptors

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The current shortage of certified nurse-midwives and certified midwives willing to serve as preceptors for midwifery education programs limits the number of students accepted into education programs. Preceptors are an essential link between academic programs and clinical practice and are indispensable to the growth of the midwifery profession. Preceptors create a safe environment for learning and teach adult learners through a variety of clinical teaching strategies. Novice preceptors need training and support to learn a new role, and experienced preceptors desire continued support and training. Before starting, preceptors need to identify sources of support and mentoring as well as understand the academic program's expectations for the student. This article draws on the clinical education literature to describe approaches to teaching all types of students. Practical strategies for integrating all levels of students into busy clinical settings are identified. Two approaches for clinical teaching, the Five Minute Preceptor and SN PPS, are discussed in detail. Strategies for providing effective feedback and approaches to student evaluation are provided.

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INTRODUCTION

In order for the midwifery profession to thrive and grow, midwives currently in clinical practice are needed to serve as preceptors for the next generation of clinicians. Despite the time pressures of the practice setting, clinical education can reward a preceptor with a deep sense of satisfaction. In a study of midwifery preceptors, more than half of the respondents reported that a commitment to supporting the profession and a love of teaching are the primary reasons that they precept students.[1] dditional incentives to precept students include professional duty, giving back to the profession, sharing and demonstrating knowledge, learning updated evidence-based clinical information from the student, and personal satisfaction.[1–6]

Despite these incentives, the current shortage of preceptors has a significant negative influence on the number of midwifery students that can be accepted into education programs.[1] The merican College of Nurse-Midwives (CNM) has a strategic goal of certifying 1000 new midwives per year. In 2014, the number of new midwives who joined the profession was 576, representing only about half the national goal.[7] Consequently, it is imperative to increase the number of dedicated clinical preceptors. Some midwives may be reluctant to precept because they are concerned about the need to cultivate an entirely new set of skills or have the misconception that they are not adequate for the role. Guidance and support need to be provided to midwives considering this new role, helping them build confidence and enthusiasm as they develop their expertise. This article reviews the clinical education literature and presents clinical teaching approaches and strategies preceptors can use to integrate students into the clinical environment. Several elements can impact the nature and quality of a clinical education experience for both the preceptor and the learner. These elements include initial preparation for precepting, clinical teaching strategies, and approaches to integrating the student into the clinical setting.

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INITI L PREP R TION FOR PRECEPTING

Precepting is a teaching-learning approach used in clinical education in most health care professions. It is an assigned, short-term, one-to-one relationship between a student and an experienced practitioner who is immediately available to the student in a clinical setting. The preceptor-student relationship has a defined beginning and end time and well-delineated objectives for clinical learning. lthough the terms are sometimes used interchangeably, the precepting role is distinct from the role of mentor. mentoring relationship is a voluntary, long-term, one-to-one relationship without an established end time. The mentor provides support, teaching, and counsel but generally does not evaluate or assess the mentee.[2,8,9]

Creating a safe environment for learning and a trusting relationship with the student is critical for an effective precepting relationship.[3,8,10–13] Students gain a valuable understanding of the importance of lifelong learning and humility when working with preceptors who are willing to share their own clinical learning and growing process. Preceptor respect for the student and the student's contribution to learning is essential to create a supportive learning environment.

Preceptors are also an essential link between the academic program and clinical practice. By enhancing critical thinking, assisting in the development of clinical and problem-solving skills, fostering independence, and promoting competency and confidence, preceptors help students develop clinical skills. Preceptors cultivate critical thinking when they bring respect, flexibility, openness, trust, safety, and the willingness to engage in questioning and debate to the preceptor-student relationship. Being constraining, remote, unsafe, or

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Quick Points

In order to grow as a profession and meet the coming shortage of health care providers, an expanded number of clinical preceptors for midwifery students is needed.

Precepting involves a new skill set that is learned over time with the support and mentoring of education program faculty.

Effective and confident preceptors model lifelong learning and professional growth for students as they share their own histories and create a safe, flexible learning environment.

Clinical teaching strategies and practical tips can help preceptors maintain clinical productivity while integrating a student into the clinical setting.

Timely, specific feedback and student evaluation are key elements of the precepting role.

reluctant to engage as equals with students can curtail critical thinking.[14]

Similar to a student's journey, the new preceptor's journey will likely include the uncertainty associated with being a novice in a new arena. Preceptors learn and gain skills while growing into the clinical preceptor role.[15] These skills are not part of initial educational training for midwives so they are understandably unfamiliar. Students appreciate preceptors who are honest about their limitations and perceive those preceptors as having authenticity and integrity.[16] The thought of being a preceptor can be stressful and intimidating to those new to the role; it is well documented in the literature that preceptors need and want training and ongoing support.[17]

It is helpful for preceptors to consider their preferred methods of teaching and learning. Learning styles influence the way a student assimilates, processes, and recalls information, and it has been suggested that optimal learning occurs when the style of instruction matches the student's learning style.[18] It may help preceptors to remember their favorite preceptors and identify what they did that was helpful in the learning experience. Table 1 lists resources for online assessments of teaching and learning styles.

Preceptors can work with beginning, intermediate, or advanced students, students with labor and birth experience, students without nursing experience, or students with hospital, home, or birth center experience. It is important for preceptors to consider what level and type of learner will be placed into the clinical setting and communicate their preferences for the type of student with whom they want to work. Preceptors are encouraged to identify the characteristics of students with whom they will work well and who will fit well in their clinical environment. preceptor also needs to consider how long to commit to a particular student. Preceptors' understanding of themselves and their preferences can help them communicate clearly with the education program clinical placement coordinator.

Identifying resources and support networks can help a new preceptor feel more confident. New preceptors may choose to share their duties with a colleague who has precepted before or find it helpful to have colleagues observe them precepting to provide suggestions and insights.[19] Sometimes institutional support may exist for precepting, such as being able to adjust clinic schedules on precepting days. Finally, preceptors are encouraged to understand the rewards provided by the institutions requesting precepting commitments. lthough only a small percentage of midwifery programs provide financial compensation for precepting,[1] studies document a wide variety of rewards for precepting, such as library access, adjunct faculty status, reduced fees for continuing education unit offerings, verification of hours toward recertification, and access to services and events on campus.[5,6]

Support and mentoring should be available from the academic program requesting precepting services. Program faculty (hereafter referred to as faculty) support for preceptors is essential and is a key element in preceptor retention.[9,10] Preceptors desire ongoing communication with and support from faculty, especially in the initial preceptor training period, during evaluations of student progress, and when dealing with challenging students.[1,10,20] Site visits by faculty provide the opportunity to discuss precepting concerns and to be mentored by faculty. If faculty do not perform site visits, new preceptors may choose to ask for assistance or investigate if there is a possibility for in-person faculty mentoring. The academic program usually provides preceptors with specific resources as well. In addition, there is a free preceptor workshop training each year at the CNM nnual Meeting, and resources are available on the CNM website.

cademic programs utilizing preceptors should provide a clear explanation of their expectations of the role.[3] Information about the length of the learning experience and the types of clinical experiences that are required for the student should be provided. The institution should also provide preceptors with details about how student evaluations are done and how the faculty plans to communicate during the learning experience.

Setting the Stage for a Successful Precepting Experience

Several steps are needed to set the stage for a successful precepting experience. It is important to create a safe environment for making mistakes since mistakes are a key element in the clinical learning process.[15] There is no place for shaming or humiliation in communication with a student. Utilizing a positive, flexible approach that includes humor and respectful communication can help a preceptor create an optimal environment for student learning.

Table 1. Online Teaching and Learning Style ssessments

Name and Website	Description
Learning styles	
V RK: Visual, ural, Read/Write, Kinesthetic http://vark-learn.com/the-vark-questionnaire/	This is a free 16-item questionnaire that identifies learning styles as visual, aural, read/write, kinesthetic, or mixed. Results indicate the individual's learning style, and strategies for learning for various styles are supplied as well. More in-depth learner profiles are available for purchase.
What Is My Learning Style http://www.whatismylearningstyle.com/learning-style-test-1.html	This is a free 30-item questionnaire to identify those with visual, auditory, and tactile-kinesthetic learning styles. In addition to providing results, users are also directed to a page with learning strategies for each type of learner.
Learning Styles Questionnaire http://kearning-styles-questionnaire-honey-and-mumford.doc	This is a free 80-item questionnaire that identifies a learner's level of preference (very strong, strong, moderate, low, very low) for the activist, reflector, theorist, or pragmatist learning styles. General descriptions of each learning style are provided as well as suggestions of activities where persons with each learning style may learn best and learn least.
Teaching styles	
Teaching Perspectives Inventory (TPI) http://www.teachingperspectives.com/tpi/	This website provides the free TPI to take as well as sections explaining the 5 teaching perspectives themselves and how to interpret your TPI results. There is a video on the results page that includes a conversation between one of the TPI creators and a teacher. In the video, they review his TPI and discuss how to interpret and apply the results.
The merican cademy on Communication in Healthcare http://www.aachonline.org/	Excellent resource for tools for effective communication with learners in the clinical setting.

Before a student starts in the clinical setting, it is important to clarify if he or she will have access to patient charts. Most sites currently use electronic medical record (EMR) systems, to which students may have access for chart review only or for both chart review and documentation; a preceptor should determine the level of access needed and what type of orientation may be required prior to the student's start date. Since the EMR system is the basis for billing for services, a preceptor needs to be aware of how student charting may impact that process. Resources for understanding documentation and billing guidelines can be found among colleagues and are also available through CNM. Preceptors may also ask students to create written notes for several patient encounters each day instead of using the charting system. Prioritizing and organizing clinical information into a succinct and comprehensive SO P (subjective, objective, assessment, and plan) note is a valuable learning experience for all students regardless of EMR system access.

Understanding where students are within their academic program and what classes they are currently taking can help inform appropriate expectations in the clinical setting. Receiving a curriculum and access to the syllabi and course content of the student's current courses can help a new preceptor recognize what a student has learned to date.[10,21] It is also important to understand the goals and objectives for the clinical rotation.

If possible, a new preceptor should arrange to meet with the student before the start of the clinical learning experience. The student can bring a list of learning goals for the clinical rotation to the first meeting with the preceptor, and the preceptor can use these to guide the clinical experiences chosen for the student. Table 2 offers a checklist of items to cover in such a meeting.

CLINIC L TE CHING STR TEGIES

variety of teaching strategies are used in clinical education, including modeling, observation, case presentations, direct questioning, think aloud, and coaching.[3] These multiple approaches to clinical teaching can help provide insight into the thought processes and clinical reasoning of the student.

Observation is a simple teaching strategy that allows for both the student and the preceptor to be the observer. It can be used beneficially with all levels of students to gain insight into both the clinical reasoning process and the hands-on provision of care. Student case presentations are an essential part of clinical education, providing students with a structured approach to the organization of clinical information and allowing the educator to assess how the student processes and prioritizes information. Various clinical teaching strategies are further described in Table 3.

Clinical Discussions With Students

Two approaches have been developed to help structure clinical discussions with students. Both of these approaches require an initial investment of time to learn how to use them.

Table 2. Student Orientation Checklist

Step	Goal
Before meeting with the student	Confirm necessary contractual and onboarding requirements are completed.
Set up a meeting	This meeting sets the tone for working together and provides a chance to introduce the student to the site. Ideal to do before the first day of the clinical rotation.
Learn about the student	Learn about the student's prior experiences, skills, and knowledge, as well as the student's self-perceived strengths, weaknesses, and areas of expertise.
Share your history/style	Share your history and teaching style. sk the student how they like to learn
Learning strategies	Discuss which learning strategies might be used in the clinical setting. Inquire about whether the student prefers the manipulated structure or the sink-or-swim approach to clinical learning (see the dult Learners section of this article).
Understand the program and courses	sk the student to provide both the course and their individual learning goals. These will help you understand where to focus your teaching and provide guidelines for measuring student progress.
Introduce to the clinical setting	If the student is in both an ambulatory and birth setting, an introduction to both sites is ideal before the learning experience starts. If that is not possible, the orientation will need to be part of the plan for the first day.
Orient student to the practice and providers	Introduce the student to staff and other providers. Let them know the length of the clinical rotation and when the student will be in the clinical setting. Help the student understand the services available at the site, the population served, and the roles and responsibilities of staff and providers. Consider arranging for the student to join other providers or staff to expand on the available learning opportunities.
Orient student to policies and protocols	Orient the student to the organizational policies and protocols that will impact them, including any specific standards or guidelines governing student behavior, dress, documentation, and access to medical records. Provide a copy of the clinical guidelines or protocols used by the midwifery practice. Orient the student to how communication between providers occurs and give the student necessary contact information.
Site specifics	Give the student a tour of the site and show them their work station, as well as where to store their belongings, eat, and park.
Student introductions	Decide how to make patients aware of the student and who will ask, and how they will ask, about student involvement in care. photo and short biographical introduction to the student can be posted in the waiting room and the examination rooms. Create a script for asking about student involvement. Introduce a student with a nursing background as a nurse who is learning to be a midwife. If the student does not have a nursing background, introduce them with other roles they have filled, such as a doula. In this way, the client hears their previous experience before hearing that they are a student.

dapted from Burns C et al, 2006[3]; Hildebrant E, 2001[5]; Sorrell & Cangelosi, 2015.[15]

However, once that is done, they provide a structured way to gain insight into a student's clinical reasoning and to teach during a busy clinic day.[10]

The One Minute Preceptor and Five Minute Preceptor Technique

The first approach is called the One Minute Preceptor, which was originally developed for use in an outpatient setting with family practice residents and has been used for more than 20 years.[10] In this 5-step, teacher-led approach, the student is an active participant and does the bulk of the work in the interaction. The focus is on differential diagnosis and management planning. It is intended to help preceptors increase both the frequency and quality of teaching occurring in complex clinical settings.[10] The model has been adapted in a variety of ways and modified for use in nursing, where it has been renamed the Five Minute Preceptor because the interaction takes approximately 5 minutes to complete.[10,11,22,23] Table 4 provides an example of how a midwifery preceptor can use this technique.

Table 3. Clinical Teaching Strategies

Teachi g Strategy	pplication
Modeling	Preceptor demonstrates clinical skills and reasoning.
	Often used with beginning students but beneficial for advanced students as well.
Observation	Preceptor and student can observe each other.
	Good to use with any level of student who is new to a site or preceptor.
	Often used with beginning students but beneficial for advanced students to do periodically.
Case presentations	Reflects the student's ability to obtain complete histories, identify and report pertinent physical findings, generate relevant differential diagnoses, and develop appropriate management and follow-up plans.
	Helps to identify gaps in student learning.
	Clarify format preceptor prefers for case presentations; may be different than format student knows.
Direct questioning	Fosters critical thinking skills and provides insight into the student's knowledge base and ability to problem solve in clinical situations.
	void situations that put the student on the spot in front of patients or staff, create stress, and/or make it difficult for student to concentrate.
	Commonly used strategies include the Five Minute Preceptor and SN PPS.
Think aloud method	Fosters critical thinking and clinical reasoning skills and enhances reflective thinking.[16]
	Encourages student to verbalize thoughts and rationale for making clinical decisions.
	Helpful technique with all levels of learners but is particularly good for beginning students.
	Useful in the intrapartum setting to understand how the student is processing information and making decisions.
Coaching	Preceptor provides verbal cues to student during performance of a procedure.
	Facilitates increased opportunities for student involvement and skill building in procedures.

dapted from Burns C et al, 2006.[3]

SN PPS: Summarize, Narrow Differential, nalyze, Probe, Plan, Select

The second approach is a technique called SN PPS, which stands for summarize the case, narrow the differential, analyze the differential, probe the preceptor, plan management, and select an issue for self-directed learning (Table 5). SN PPS is a 6-step, learner-centered model upon which discussions between preceptors and students can be developed. The focus of this technique is on case presentation and diagnosis. s opposed to the Five Minute Preceptor, both preceptors and students need to learn this technique in order for it to be used. Responsibility for leading the teaching encounter is shifted to the student; therefore, this technique might be best for advanced and/or highly motivated students.[24] Steps 1 through 3 of the process are student led, step 4 involves the preceptor, and step 5 is collaborative. The student is responsible for step 6. There is no feedback step in this technique as there is in the Five Minute Preceptor, so feedback should be integrated into step 4.

INTEGR TING THE STUDENT INTO THE CLINIC L SETTING

Midwifery students are best viewed as adult learners. They enter midwifery education with a certain level of expertise from previous roles, and they function and learn best in situations that value their individual experiences and backgrounds. Learning is enhanced if they can see the relevance of what is being learned and if they believe progress is being made.[3,12]

dult Learners

dult learners are a diverse group of mature students with varying cultural and educational backgrounds and past experiences that they bring into the current learning environment.[24] dult learners are experiential learners who want to be active participants in the learning process rather than passive recipients of information. They want to integrate their past lives into their emerging roles as advanced practice nurses.[3] Further information on adult learning is discussed in Dyer et al.[25]

There are several approaches for teaching adult learners in a clinical setting. In the *manipulated structure* approach, the student sees women who are carefully selected based on the student's previous experience and skill level. This approach is often used for beginning students and is useful in regulating the amount of anxiety a novice faces. beginning student may see 3 to 4 women a day, taking a history and doing patient teaching, while the preceptor does other visits during that time. There is a lot of previsit, during, and postvisit consultation with the preceptor. Cases increase in number and complexity as the student's clinical skills develop.[3]

second approach, sometimes called "sink or swim," is used more often with advanced students.[3] In this approach, there is little previsit teaching. The student is exposed to a variety of patient encounters and is expected to conduct the visits independently. However, the preceptor is available to help at all times. This approach provides a level of independence and challenge that works well for more advanced students.

Table 4. Five Minute Preceptor Strategy for Clinical Teaching with Examples

Step	Preceptor	Lear er	Practical Tips
Background	Be ready to actively listen and engage for 5 minutes.	"TC is a 17-year-old G1 here for a return prenatal visit at 38 weeks 2 days. She presents today with an initial BP of 144/92. Repeat BP 138/86; +fetal activity; no leaking, contractions, or vaginal bleeding. Her usual blood pressures are in the 110-124/67-80 range.	Invite the learner to present the HPI and other relevant information. Student may want the preceptor to supply the assessment and plan. void adding your thoughts at this point.
sk for a commitment	"What do you think is going on?"	"I am concerned about her elevated blood pressure. She could have preeclampsia or gestational hypertension."	May ask student to expand the differential to include other etiologies of increased blood pressure. The key is to get student to make a commitment to their thought process and differential diagnosis, even if incorrect. void answering for student.
Probe for supporting evidence	"Why do you think that is what is going on?"	"She has elevated blood pressure that is concerning and is above her normal range, and she is in the latter part of the third trimester when these issues often arise."	The goal is to encourage the student to display their knowledge base and thought process.
Provide management guidelines	"Preeclampsia is more commonly seen in women having their first babies and often occurs later in the third trimester. It is important to distinguish it from gestational hypertension and other causes of elevated blood pressure."	Learner listens.	This is where general management guidelines about the clinical situation are taught by the preceptor. Teach a maximum of 3 points in this stage.
Reinforce what was done correctly	"You did a good job identifying that her blood pressure was elevated by both diagnostic criteria and above her norm by evaluating her BP history in pregnancy. That helps you to interpret what is going on today."	"Thank you."	Comment on the strengths of student's thought process. Reinforce what student did well so that student can apply those actions to similar situations.
Correct mistakes	"You didn't evaluate this woman for any of the signs and symptoms of preeclampsia including asking about headache, visual changes, or epigastric pain. It is important to understand if these symptoms are present."	"I will remember to do that next time."	May start by asking the student to assess their performance. Constructive feedback should be based on student behavior and provide specifics for improvement.

bbreviations: BP, blood pressure; HPI, history of present illness.
dapted from Pascoe et al, 2015.[22]

Student Involvement in Patient Care

Before the day begins, the preceptor and student should meet to review the clinic schedule, identifying appropriate visits for student involvement. t that time, the preceptor and student can discuss the day's learning goals, and the preceptor clearly communicates the expectations for the number and types of women to be seen that day, the amount of time the student will have to spend with the woman, and the amount of preceptor time available to the student, which will help the student perform optimally.[3] s the student integrates into the clinical setting, the preceptor will identify strategies for clinical learning that are appropriate for each student and applicable to the clinical learning environment in order to balance learning opportunities with the need to maintain the clinical practice.

Beginning Students

In working with the beginning student, preceptors need to focus on building skills and clinical reasoning over time. The student starts out observing and moves to doing progressively larger portions of visits or procedures as appropriate. s the

Table 5. SN PPS Strategy for Clinical Teaching With Example

Step	Learner	Preceptor	Practical Tips
Summarize	"TC is a 17 year old G1 here for a return prenatal visit at 38 weeks 2 days. She presents today with an initial BP of 144/92. Repeat BP 138/86; +fetal activity; no leaking, contractions, or vaginal bleeding. Her usual blood pressures are in the 110-124/67-80 range."	Be ready to actively listen and engage for 5 minutes.	This is a learner-led process that begins with a summary of the clinical case by the student.
Narrow the differential	"She could have preeclampsia. It could also be white coat hypertension."	"What else could it be?"	Encourage learner to fully consider a range of differential diagnoses and then narrow to three possible diagnoses.
nalyze the differential	"The most likely diagnoses are preeclampsia or gestational hypertension. This woman has never had white coat hypertension at her visits."	"Those are the most likely diagnoses. You did a good job identifying that her blood pressure was elevated by both diagnostic criteria and above her norm by evaluating her BP history in pregnancy. That helps you to interpret what is going on today."	Learner should be able to identify critical factors in the diagnostic process related to the clinical issue being considered.
Probe the preceptor	"I know that elevated blood pressures can indicate a problem, but I was not sure how to interpret her repeat blood pressures this visit since the repeat blood pressure is not technically elevated but is elevated for her."	"You are right to consider her blood pressures in light of her blood pressure history both before and during pregnancy. What are other important elements to consider when evaluating a patient for preeclampsia or gestational hypertension?"	This is the place to point out things that were missed and for the learner to ask questions that might be difficult to look up. Guide learner to the correct answer by helping to identify and apply past learning.
Plan management	"For the next step, I will order a preeclampsia panel and a test for urine protein. I will ask her about headache, visual changes, and epigastric pain. Those things will help to clarify what the issue is."	"That is a great start to the plan."	llow the student to fully present their plan before adding anything.
Select a case-related issue for self-directed learning	"I would like to better understand the diagnostic criteria for preeclampsia and gestational hypertension."	"Great, there are some very good articles in the literature for you to read."	llow 5-10 minutes to discuss learner's findings at the next clinical encounter.

bbreviations: BP, blood pressure.
dapted from Pascoe et al, 2015.[22]

student progresses, the preceptor can become less involved, and the student is allowed to work more independently. s the student gains skills, the preceptor may be in the room with the student for some visits but lets the student take the lead for portions of the visit. In that situation, the preceptor needs to develop strategies to direct the woman to interact with the student. If possible, the preceptor should sit behind the woman or student so that the woman makes eye contact with the student.

If that is not possible, the preceptor can redirect the conversation by inviting the student to answer or comment.

Midwifery students are often uncomfortable with preceptor observation and want to move quickly to independent practice. While independence is certainly appropriate at times, preceptors should be wary of giving it too quickly. Observing the student provide patient care allows the preceptor to truly understand how a student functions in the clinical setting and to provide specific feedback related to the clinical encounter. Observation also gives the student and the preceptor a chance to share impressions of a given clinical case, think through the case together, and develop differential diagnoses and plans of care.

The student can start out doing skills, such as fundal heights or speculum examinations, for every visit while the preceptor runs the rest of the visit. s the student builds skills and familiarity in the clinical setting, it will be appropriate for them to begin to do a few visits each day with more independence. The key at this stage is quality and not quantity; the student should see several women with uncomplicated pregnancies over the course of the time in clinic to learn to develop a systematic approach to care that includes reviewing the chart, identifying priorities for the visit, conducting the history independently or with the preceptor observing, and being involved in the physical examination, and in the creation of an assessment and plan.[3] The student can prepare for the visits they will attend while the preceptor is conducting other visits. Being able to see women of a similar gestational age or with similar needs helps to cement learning for the student.

Intermediate Students

s the student moves from the beginner to transitional level, the preceptor can progressively step back. In this stage, the student should be able to establish basic priorities for each visit, gather the essential relevant data in a history, and generally conduct the visit with better efficiency and effectiveness.[3]

ppropriate clinical teaching strategies for this level of student would include case presentations, direct questioning, and the think aloud method. The think aloud method involves students voicing their thought process and rationale for clinical decision making. The preceptor can start to identify women with progressively more complex pregnancies for the student to see, as well as have them maintain involvement in uncomplicated visits. The preceptor can ask students to do work outside of the clinical setting to review relevant theory or solidify clinical knowledge. t this level, students should be able to give more concise and organized case presentations. They will be more efficient with time and resources, require less prompting, and have more developed diagnostic reasoning and management planning skills.[12] While the focus for this student is building capacity in the clinical setting, the student should still focus on quality versus quantity and gradually build up the number of patient experiences each day.

dvanced Students

The advanced student is a competent and proficient learner and is ready to see progressively more women, and women with more complex pregnancies, in a clinical day. The student is as independent as the setting allows, with frequent reporting back to the preceptor.[26] It is important for the preceptor to be able to let the student have more independence in thinking as well as in clinical activities. The key is for the student to be proficient at developing safe management plans based on sound clinical evidence. Even if the plan is not what the preceptor might choose to do, it is appropriate that the student proceed with the plan if it is safe and reasonable. The student is aware of any limitations and is unafraid to ask questions as needed to practice safely. This student should be able to perform all the role functions of a midwife for an increasingly complex caseload in a thorough, efficient, organized, skillful, and independent manner.

Integrating the Student Into a Busy Clinic

Having a student inevitably adds to a clinic day's complexity.[3] Contrary to popular belief, however, preceptors do not always have longer days or spend more time with women, and productivity does not always decrease when working with a student. Some studies have shown that productivity may actually increase, as students who are able to do some portions of a visit independently can contribute to a midwife's clinic productivity.[6]

Sequential Involvement in Prenatal Care for the Beginning Midwifery Student

There are several approaches to integrating students into visits. One approach, consistent with the manipulated structure teaching strategy, focuses the student on limited portions of multiple visits.[27] The student and preceptor see women together throughout the first clinic day, during which the student participates in measuring fundal heights and listening to heart tones in most visits. t the end of that day, the preceptor asks the student to create a template for routine prenatal visits for women between 12 and 24 gestational weeks. The next clinic day, the student conducts histories for women in those gestational ages, then creates a template for visits with women between 24 and 36 gestational weeks. On the third clinic day, the student participates in visits with women who are between 24 and 36 gestational weeks, then puts together a template for conducting visits with women between 36 and 42 gestational weeks. In this way, the student sequentially expands capacity to manage prenatal visits without slowing the clinic flow. This approach also allows the student to learn by observing the preceptor conduct visits and allows time for the preceptor to observe the student and provide feedback. However, some students may find this approach fragmented and find it difficult to understand how to conduct a whole visit.[27]

Wave Scheduling

Preceptors may also integrate students into a busy clinic day using an approach called *wave scheduling*. With wave scheduling, 2 women are scheduled at the same time in the first time slot, one woman in the second time slot, and no one in the third time slot. The preceptor and student start off doing separate visits in the first time slot. The preceptor does visits more quickly, moving on to see the woman in the

Table 6. Practical Strategies for a Busy Clinic Day

Table 6. Practical Strategies for a Busy Clinic Day
Set limits on available teaching time
Student can set timer to keep track of time spent
Provide recommended timelines to student
10 minutes to obtain as much history as possible
5 minutes to present history, physical examination, diagnosis, suggested plan
Patient assignment and involvement with students
ssign to familiar patients to make evaluation of student's accuracy quicker
ssign to women who enjoy extra time and attention
Consider doing case presentations in the examination room so the woman can be involved in clinical teaching
Practical tips for efficient visits with students
Electronically chart in patient room while student does history or physical examination
lternate who does the history and who does physical examination when seeing women together, so student gets practice at both but visits are not as long
Student charts on previous encounter while preceptor sees the next woman
In order to avoid embarrassing the student, identify a password or nonverbal cue to be used when student needs help or you want to step in

dapted from Burns et al, 2006[3]; Hayes, 1994[12]; Sorrell & Cangelosi, 2015.[15]

second time slot while the student continues with woman 1. In slot 3, the preceptor has time to discuss woman 1 with the student and then go in while the student completes that visit. In terms of scheduling, 3 women were still seen in 3 slots. Even if patients are not formally scheduled in this manner, it does help to carve out time for teaching while allowing the preceptor to stay on schedule.[3] This method also allows students to be involved in all parts of a woman's visit and to begin seeing the larger clinical picture.

dditional practical preceptor strategies that can be used to keep a teaching day focused and on time can be found in Table 6.[3] Teaching does not need to occur during every patient visit; it is appropriate for a preceptor to take over provision of care in complex or high-risk situations, or when a given situation is not conducive to teaching. The student will still learn by observation while the needs of the woman are met.

FEEDB CK ND EV LU TION

Timely feedback and evaluation are key aspects of the clinical education experience. Feedback communicates information and focuses on what was done and the potential consequences of those actions. Evaluation conveys a judgment that is made about the student's performance in comparison to established goals for the clinical learning experience.[3,21,28] Self-assessment and reflective practice are keys to becoming a competent clinician and important to include when providing feedback and evaluation.[21] By giving a student an opportunity to reflect and comment on what went well, what could be improved, and how improvement can occur, preceptors find that students often identify the same problems or concerns that the preceptor would identify. Self-assessment instills confidence in the student and reduces fears of reprisal or incivility.[16]

Types of Feedback and Evaluation pproaches

Formative feedback is provided on a frequent basis to students as they progress through the clinical learning experience. *Summative feedback*, or evaluation, is given at specified points in a learning experience, most frequently at the end of the experience. Both formative feedback and evaluation are essential to supporting a student's growth in the clinical learning process. Studies investigating student satisfaction with feedback in medicine and pharmacy have found that there is a disconnect between how often preceptors think they give feedback and how often students perceive it has been given.[28] To address this, it is important that preceptors preface formative feedback sessions by letting the student know the intention of the meeting.

There are several approaches to providing feedback. In the *directive approach*, the preceptor relays observations about a student's performance in a clinical encounter. The goal is for the preceptor to deliver information; the student is not actively involved in the process. The *elaborative approach* encourages the learner to be actively involved and reflect on their performance and skill set. Here, the focus is on self-reflection and assessment. The elaborative approach creates an atmosphere of trust and promotes more effective feedback. key element in the elaborative approach is that it is reciprocal and includes the preceptor asking about what went well in the clinical learning experience and what the preceptor could have done differently to improve the learner's experience or achievement of learning goals.[28]

Factors That Influence the Process of Giving Feedback

Several factors influence the quality and process of providing feedback. Environmental factors include the frequency, location, and timing. Feedback should be provided in a neutral, private setting, given regularly, and occur close to the event that warrants discussion. Reassurance and positive reinforcement given throughout the day can emphasize areas of practice that are performed well. Ideally, feedback is provided at the end of each clinical day. This will help ensure that both the student and preceptor remember the situation being addressed well. Providing feedback does not have to take a long time and can often be done within 5 minutes.

Interpersonal factors relate to the personality factors and learning and communication styles of the student and preceptor. Differences in those factors and styles can impact how effectively feedback is given and received. The understanding gained when the student and preceptor discuss learning and teaching styles early in the learning experience can help inform how feedback is given and received.

Situational factors relate to the feedback content and are critical to consider in order to provide positive or

constructive feedback. Drawing on notes taken throughout the day, preceptors can provide short, specific positive or constructive feedback related to the care given. During this exchange, the preceptor can ask how the student felt about their care, inquire where the student wants to focus next, and discuss how the day worked for both the preceptor and the student.[3,15] This will provide both the student and the preceptor with the opportunity to reflect on the achievement of that day's clinical goals and to identify learning goals for future days. Some students may focus only on negative aspects and can be redirected to focus on what went well before the preceptor provides constructive feedback.

Most preceptors are more comfortable providing positive feedback and often avoid constructive feedback. One technique for providing constructive feedback is called the *feedback sandwich*. In this case, the preceptor provides positive feedback, then constructive feedback, and finishes with positive feedback.[26] Constructive feedback needs to be given respectfully and needs to be specific about what was done well and what needs improvement.

When evaluating students, it is essential that the preceptor understand the academic program's evaluation requirements and be familiar with the evaluation tool. It is also important to know how many evaluations are required during the course of the clinical learning experience. ll academic programs require an end-of-learning-experience evaluation, but some also ask that one be done halfway through a quarter or semester. Evaluations should not hold any surprises for students since they should have been made aware of any preceptor concerns as soon as possible after the concerns arose. Evaluations help the student see the big picture of their learning process and move forward developmentally.

CH LLENGING SITU TIONS

Reasons that students might need to fail a clinical learning rotation include an inability to prioritize care, a lack of preparedness, gaps in knowledge base, inability to incorporate theory into clinical practice, unprofessional behavior, personal problems, unsafe care, and poor communication. New preceptors are not expected to be experts in handling challenging situations or students. It is often difficult for clinical educators to recognize in a timely manner when a student needs to fail the clinical experience.[15] Preceptors may be tempted to wait, sometimes for an extended period of time, to see if a problem gets better; however, faculty should be notified immediately if a student has any significant problems in the first few weeks. Preceptors, faculty, and students all need to be involved in the resolution of student performance problems in the clinical setting. The faculty should be readily available to problem solve with the preceptor and identify solutions. Preceptors should not hesitate to ask the faculty for an in-person site visit when possible. The Dyer et al article reviews how to work with students who are failing to meet expectations.[25]

CONCLUSION

Preceptors play an integral role in midwifery education and are indispensable in the clinical training of student midwives. The current lack of clinical preceptors limits the number of midwifery students that can be accepted into education programs. Clinicians may be intimidated about precepting and choose not to precept. systematic approach, knowledge of educational goals, tools for teaching, and flexibility are key to precepting and can make precepting a very satisfying experience. The strategies and techniques described in this article offer an approach and set of tools that can help all preceptors, particularly beginning preceptors, be successful as clinical educators. Precepting offers many rewards, including the chance to watch and participate in the transformation of a student into a new midwife.

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CONFLICT OF INTEREST

The author has no conflicts of interest to disclose.

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