Clinical education is viewed as the hallmark for bridging the gap between theory and practice and is an integral part of all medical education programs. Clinical practitioners are highly educated in the sciences and courses specific to their expertise (e.g., athletic training versus physician assistant), but usually receive no formal instruction in pedagogy. The conflict between preceptor expectations and lack of formal training may result in role strain and negatively impact the clinical learning experience. Ongoing athletic training educational reform has fostered a split between academic and clinical athletic trainers (ATs), leading to a lack in communication and cooperation. It is important for athletic training clinical education coordinators (CECs) and program directors (PDs) to explore methods for developing ATs as preceptors that promote communication and collaboration.

Similar to the preparation of preservice athletic training students, teacher education programs also rely on field experiences as an integral part of teacher preparation by placing students in the classroom to prepare them as effective and competent teachers. Teacher education programs and schools use various methods for assisting in the continued development and improvement of teacher practice. One common model used in teacher education is clinical supervision, a collaborative process that allows for face-to-face contact that develops empowerment and trust as the teachers examine their own teaching practices. Acheson and Gall developed a three phase model of clinical supervision which was comprised of a planning conference, classroom observation, and a feedback conference. This systematic process of clinical supervision highlights classroom observation and feedback as a means to promote improved teaching. The process provides the teacher with objective data on performance versus the individual teacher’s perception of their performance. There are five goals of clinical supervision: (1) to provide teachers with objective feedback on the current state of their instruction; (2) to diagnose and solve instructional problems; (3) to help teachers develop skill using instructional strategies; (4) to evaluate teachers; and (5) to help teachers develop a positive attitude about continuous professional development. A recent study employed this conferencing model as a preceptor training program to evaluate its impact on the use of effective preceptor behaviors and examine preceptor perception of its influence on their behaviors. The results showed an increase in use of positive preceptor behaviors, with a decline in the use of behaviors that do not engage the student and a positive preceptor perception of the training program.

**Key Points**

- Clinical conferencing has a positive impact on preceptor behavior.
- Clinical conferencing provides an objective approach to providing data to preceptors.
- Clinical conferencing is an effective method of preceptor training.
The Conferencing Cycle

Planning Conference

The process of clinical conferencing begins with a conversation between the CEC (or designated supervisor) and preceptor. The CEC uses strategic questioning to clarify the preceptor’s perceptions in relation to the process, personal concerns, needs, and objectives relative to his or her current level of teaching practice in comparison with what is viewed as ideal. The CEC and preceptor collaborate to set clear goals, develop a timeline, identify methods for collecting and analyzing observational data, and select specific behaviors to be observed. The planning conference does not require a large time commitment; the initial meeting may take 20–30 min, while follow-up sessions may only last 5–10 min. The conference should be held at a neutral site, one in which the preceptor will feel at ease; it is important for the atmosphere to support open discussion without the fear of evaluation.

Clinical Experience Observation

During this phase of clinical conferencing, direct or indirect methods of observation are used to provide preceptors with indicators of preceptor performance. Indirect methods may include information that demonstrates student performance (e.g., test results or skills checklists) or subjective evaluation of preceptor behavior (e.g., student/preceptor surveys), while direct methods may include video recording, audio recording, or physical presence as a means for gathering objective data (e.g., jott notes). The specific technique may range from selective verbatim, a written record of what the preceptor actually said, to the use of an observational record of specific preceptor behavior that is recorded at specified intervals of time, usually measured in seconds. The records are analyzed using steps appropriate to the data gathering technique, such as examining the written record of selective verbatim for types of questioning or amount of information provided, and providing frequency of use of specific teaching behaviors recorded in a timeline observational record.

Feedback Conference

Following the analysis of objective data gathered, the CEC and preceptor collaborate to interpret the information; together they look for probable causes and consequences of observed behavior, as well as alternate suggestions. For example, data may indicate that a preceptor spent 50% of the clinical experience providing patient care with no student interaction. Although observation provides some learning opportunity, if the experience does not include active learning the student is less likely to be engaged and interested. The CEC and preceptor would discuss appropriate activities for encouraging active learning and increased student engagement, initiating the discussion of new goals and the start of a new clinical conferencing cycle with the planning phase.

Case Example

The clinical conferencing process was conducted over a four-month period during the preceptor’s in-season schedule. The first planning conference session focused on the data provided from summative student evaluations of the preceptor (male, four years of experience) from the previous two years, which was used as a springboard for planning the first observation session, including preceptor goals and observational technique. The preceptor was provided with the data before the initial meeting to allow for time to reflect. During the initial planning conference, the preceptor expressed his inability to identify his strengths and weaknesses in terms of specific preceptor behavior based on the data provided. The Observational Record of Clinical Educator Behavior (ORCEB) was selected as the method for the clinical experience observation to provide quantitative measures of time spent in specific preceptor behavior categories. Specific behavior categories include:

1. Physical presence: unrelated behaviors, patient treatment without interaction, active observation
2. Information giving: explaining, demonstrating, referral to reference sources
3. Evaluation: specific positive feedback, corrective feedback, general praise
4. Questioning: low-level, high-level, peer teaching

The different behavior categories were discussed with the preceptor with an emphasis on student feedback, which was an area indicated as a weakness in student evaluations.

A minimum of two weeks between the planning conference and observation session was selected to allow the preceptor time to address the goals set during