The “One-Minute Preceptor”
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Objectives

At the conclusion of this discussion, the participant will:

• Identify different settings of clinical teaching and understand which setting may be more conducive to a specific teaching skill
• Understand the 5 microskills that constitute the “one-minute preceptor”
• Recognize consequences of over-emphasis of any particular teaching skill
• Utilize the “one-minute preceptor” process in clinical teaching
Dr. Johnson has no conflicts to declare in presenting this topic
Settings for Clinical Teaching

TNTC

- Grand Rounds
- Classroom
- PBL
- Clinical skills workshop
- Inpatient wards
- Ambulatory clinic
- Office practice
- and many, many more...
Settings for Clinical Teaching

Focus on ambulatory clinic/office practice

Typical circumstances:

- Ambulatory/outpatient
- Usually one-on-one learner and preceptor
  - Classically student or resident with attending physician
  - Can be fellow with attending, or student with resident
- Sequential activities
  - Student/resident sees patient
  - Student/resident presents patient case to preceptor
  - Preceptor and student/resident discuss the case
  - Student/resident, +/- preceptor, return to patient room
Characteristics of ambulatory/office setting:

- Experienced preceptor-teacher with less experienced student/resident learner
- Ambulatory implies not seriously ill
  - Often smaller number of issues at any one visit
  - ICU, ED, OR settings may be more suited to different style of teaching
- Time pressure
  - Visits short with lots of clinical issues/decisions to consider
  - Any teaching needs to be specific; not the setting for expansive lecturing
Characteristics of ambulatory/office setting (cont’d):

- Frequent distractions and interruptions
- In our setting (VTC/Carilion), often significant socioeconomic considerations in our patients
Opportunities:

– One-on-one; full attention by preceptor

– Assess student/resident communication and clinical exam skills

  ✓ Information gathering

– Assess thought processes and knowledge (cognitive skills) more than procedural ability

– Emphasizes clinical thinking
“One-Minute Preceptor”

- Originally described by FM doctor (ambulatory preceptor) Jon Neher in Seattle. Further adapted and refined by David Irby, now in San Francisco
- Actually developed from technique used in pharmacy school teaching
Five Microskills

- Get a commitment
- Probe for supporting evidence
- Teach general rules
- Reinforce what was done right
- Correct mistakes
Get a commitment

- Encourages student/resident ownership of the case
  - Not simply information gathering but processing
- Avoids decision making hand-off to preceptor
  - Student/resident expected to use own knowledge and information to support a diagnosis or plan
Microskills

Get a commitment

• “What do you think is going on?”

• “What tests do you feel are indicated?”

  • ("Of course, to order a test you need to put down a diagnosis, so what’s your working diagnosis?")

• “What can we accomplish at this visit?”

• “What does the lack of response to previous efforts tell us?”
Microskills

Get a commitment

Considerations:

– May need to ask data questions but limit these in hopes student/resident presents on his/her own

– Need not be a diagnosis; may commit to lab test or xray or consultation
  • However, would encourage “working diagnosis”

– Remain sensitive to student/resident strength of commitment; don’t force when clearly don’t know
  • Risk of student/resident withdrawing (“clamming up”) and losing teaching opportunity
Get a commitment

Considerations (cont’d)

– Recognize when student/resident directs discussion to have preceptor give clinical thinking
  • This comes later – “teach general rules”

– Avoid belittling
Microskills

**Probe for supporting evidence**

- Confirms student/resident used diagnostic reasoning to arrive at conclusion
  - Not just “lucky guess”
- Inquire about key information
- Discuss what one will learn from confirmatory information (tests, treatments, next steps)
Microskills

Probe for supporting evidence

• “What were the major findings that led to your conclusion?”
• “What in the patient case led you to choose that particular medication?”
• “What other diagnoses did you consider, and why do those not fit?”
Microskills

Probe for supporting evidence

Considerations:

• This microskill may also be called “probe for missing information”
• Don’t pass judgment, or praise (that comes later)
• Avoid temptation to grill the student/resident
  – Allow “thinking out loud” without risk
• Confirm knowledge base
• Not yet time to contradict (correct mistakes)
Microskills

Teach General Rules

- Identify missing information not considered by student/resident
  - Gaps in knowledge, data, or missed diagnostic connection
- Requires preceptor “diagnose” the learner’s inaccurate conclusion or absent information
  - Sophisticated expectation of preceptor; hearing about case and diagnosing the case at same time as diagnosing the student/resident learning need
**Microskills**

**Teach General Rules**

- “In a kid with URI, it’s not enough to listen to lungs – always examine the ears”
- “In a young person with mechanical low back pain, x-rays are usually not helpful”
- “In our patient population, we always have to consider the cost of antibiotics”
Microskills

Teach General Rules

• Considerations
  – This is the “teaching point”
    • Apply to current case but try to make generalizable
    • Identify gaps in knowledge or clinical reasoning
    • Ideally will be basis to return to patient room for more history, symptom, or physical exam information
  – Student/resident should be able to apply to other cases
Microskills

Teach General Rules

• Considerations
  – Opportunity for mini-lecture
    • Time constraints – recall student/resident is also concerned about time
    • Again, keep generalizable
  – Realistic time to include:
    • Non-medical, i.e., socioeconomic, issues
    • If the preceptor admits beyond scope of his/her ability, teach principles of referral/consultation
  – If student/resident has done well, OK to skip this step
Reinforce what was done right

- “Catch ‘em being good!”
- Be specific; more than simply “a good job”
  - Specific line of questioning; interpretation of conversation; physical exam; finding data
- Ideal if something that can be generalized to other cases
Reinforce what was done right

• “Very good to find that xray report, especially since it was done a year ago”

• “You were right to continue questioning this lady until you got the real reason for her visit”

• “It’s good to consider if this med would interfere with your patient’s enthusiasm for sports”
Microskills

Reinforce what was done right

• Again, requires preceptor process and analyze the learner as well as process and analyze the case
Microskills

Correct Mistakes

- This is difficult – similar to giving bad news
- Consider timing
  - May not always be best done at time of patient visit; may choose to wait until end of clinic
    ✓ Unless the mistake would really cause a medical misadventure
- May also wish to find a more private setting
Correct Mistakes

• “I agree interstitial cystitis can give changes in the UA but, common things being common, a UTI really is more likely”

• “Yes, a CT scan of the sinuses might find mucosal thickening, but it’s unlikely another expensive test would change the plan”
Microskills

Correct Mistakes

• Again, be specific
  – Identify a knowledge gap, error in clinical processing, missed physical exam finding, etc.
  ▪ Don’t grill the student/resident to come up with the mistake
    – Don’t say “Well, you messed that up royal!”
• Not the time for a mini-lecture, though could suggest “homework”
  – Student/resident won’t be listening anyway!
• Don’t be pejorative
Microskills

• Get a commitment
• Probe for supporting evidence
• Teach general rules
• Reinforce what was done right
• Correct mistakes
One-minute Preceptor

https://www.youtube.com/watch?v=t9ytKlq8wL0
Clinical Teaching Methods

“Aunt Minnie” Method
(waddle and quack)

• Pattern recognition

• May be as simple as:
  1. Student/resident works up the patient
  2. Gives quick overview, perhaps as little as chief complaint and presumed diagnosis or next step
  3. Preceptor confirms and supports with 1-2 positive comments, or corrects mistake
  4. Onto next case
Clinical Teaching Methods

“Aunt Minnie” Method

• Time efficient in very busy clinic
• Preceptor able to supervise multiple persons
• Drawbacks
  – “Snap judgments” (pattern recognition)
    ✓ Checklist medicine; doesn’t encourage thoughtful collection of data and clinical reasoning
  – Not really teaching
  – Preceptor centered, not student/resident centered
Model Problem Solving

• Preceptor demonstrates clinical problem solving
  – “Here’s how I would work through this case”

• May be used with complex cases, or if student/resident simply missed the case entirely
  – Can actually structure discussion following microskills model

• Removes pressure from student/resident to “perform,” he/she may be more receptive
Clinical Teaching Methods

**Learner-centered Precepting**

- Requires student/resident to identify his/her own learning issue

- Sees patient, collects information, presents case without preceptor comment – then raises his/her own learning question
  - “It’s clear to me this diabetic has failed oral meds. How do I start insulin treatment?”

- Assumes sophisticated student/resident
  - He/she will have correctly diagnosed the case and diagnosed the knowledge or practice deficit
Clinical Teaching Methods

Learner-centered Precepting

- Often more suited to fellows, or conversations with colleagues or as a consultant
- Teaching lies beyond “general rules” and learning is very narrow and specific
**Clinical Teaching Methods**

**SNAPPS**

*Student/resident led interaction*

- Summarize briefly history and findings
- Narrow the differential to 2-3 possibilities
- Analyze the differential by comparing and contrasting possibilities
- Probe the preceptor by asking questions about uncertainties, difficulties, alternatives
- Plan management for patient’s issues
- Select a case-directed topic for self study
“One-Minute Preceptor”

**Microskills**

- Get a commitment
- Probe for supporting evidence
- Teach general rules
- Reinforce what was done right
- Correct mistakes
Some Caveats

- Similar to technique of giving feedback; skills are readily transferable
  - Some would reverse microskills 4 and 5, so “correct mistakes” comes before “reinforce what was done right”
    ✓ Reversing 4 and 5 ends interaction on more positive note

- VTC students attuned to small group/learner-led settings; student/residents from more lecture-based schools might have to be taught this interactive technique
Some Caveats

- Probably most important microskill is “get a commitment”
  - Most demanding of student/resident
  - Sets tone for remainder of interaction
  - Reinforces focus of interaction on student/resident

- In some settings, OK to skip one or more of the other microskill steps
  - If presentation well-supported, might skip “probe for supporting evidence”
  - There may be no obvious mistakes to “correct”
“One-Minute Preceptor”

Microskills

• Get a commitment
• Probe for supporting evidence
• Teach general rules
• Reinforce what was done right
• Correct mistakes
References


