

William Huang, MD
Feature Editor

Editor's Note: The "One-minute Preceptor" is a widely accepted teaching model that summarizes important tasks or "microskills." In this month's column, Jon Neher, MD, and Nancy Stevens, MD, MPH, explain the five microskills in the model and give specific suggestions on how office-based teachers can use them in their interactions with learners.

I welcome your comments about this feature, which is also published on the STFM Web site at www.stfm.org. I also encourage all predoctoral directors to make copies of this feature and distribute it to their preceptors (with the appropriate *Family Medicine* citation). Send your submissions to williamh@bcm.tmc.edu. William Huang, MD, Baylor College of Medicine, Department of Family and Community Medicine, 5510 Greenbriar, Houston, TX 77005-2638. 713-798-6271. Fax: 713-798-8472. Submissions should be no longer than 3–4 double-spaced pages. References can be used but are not required. Count each table or figure as one page of text.

The One-minute Preceptor: Shaping the Teaching Conversation

Jon O. Neher, MD; Nancy G. Stevens, MD, MPH

In 1992, the five-step "microskills" model of clinical teaching—commonly known as the One-minute Preceptor—first appeared in the family medicine literature.¹ The method is used in medical training settings where a learner initially assesses a patient and then seeks help from a preceptor. The One-minute Preceptor is a framework around which teacher-student conversations can be built and is particularly helpful for newer teaching

clinicians. It is quite brief, easy to learn, and has been shown to improve key teaching behaviors.^{2,3} In the decade since it was first described, it has been widely adopted in fellowship and teaching programs. This article reviews the method and includes some tips on its application.

The One-minute Preceptor consists of five tasks or microskills that you try to accomplish when discussing a clinical case that a learner has just presented. The microskills are (1) Get a commitment, (2) Probe for supporting evidence, (3) Teach general rules, (4) Reinforce what was done right, and (5) Correct mistakes.

This sequence fosters learner ownership of the clinical problem and allows you to both identify gaps

in the learner's knowledge base and focus teaching appropriately to learner needs. Once familiar with the steps, you may want to modify the order, or use only selected microskills as they fit the situation. In learning the skills, it helps to focus on one skill at a time in a given clinical teaching session. Taking a few minutes at the end of the teaching day to reflect on your microskill use hastens acquisition of the skills and comfort with the method.

Get a Commitment

The first microskill is used immediately after the learner has presented a patient to you and asks a specific question or remains silent—asking, in effect, "What do I do now?" To get a commitment, you simply ask in a nonthreatening way,

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From the Valley Medical Center Family Practice Residency, Renton, Wash (Dr Neher); and the Department of Family Medicine, University of Washington (Dr Stevens).

“What do you think is going on?” or “What do you want to do?” Your objective is to get the learner to process the information he or she has just collected concerning the patient.

Occasionally, you will need to ask one or two clarifying questions about the presentation before you ask for a commitment. Questions such as “Does the child have a fever?” are reasonable, but avoid the temptation to ask so many questions that you take over the case.

Often, you can teach learners to begin with a commitment. This saves time in precepting, helps learners identify their own areas of weakness, and allows you to attend to key clinical details during the case presentation.

Making a commitment can be difficult for some learners because of the risk of being wrong and concerns about being evaluated. The question, “What if I weren’t available, what would you do for this patient?” will often get around this impasse. A general statement to the learner before you start—“I am particularly interested in what you are thinking because it helps me be a better teacher”—may encourage them to share their thinking more openly.

For more-advanced learners, remember that commitments may focus on any aspect of clinical care, including diagnosis, diagnostic trees, treatment plans, follow-up, etc. Learners should be constantly challenged to make intellectual commitments just beyond their level of comfort. In very complex cases, commitment requests may take the form of “How do you plan to find the diagnosis?” or “What do you plan to write for admission orders?” or “How are you going to chip away at this situation?”

Probe for Supporting Evidence

Next, you ask the learner what underlies his/her commitment. This has been described as exploring the

learner’s “mind map,” pieces of information (basic science or clinical) that may be loosely connected to each other.⁴ To explore the learner’s fund of knowledge and ability to connect different pieces of information on his or her mind map, you can ask questions such as, “What factors did you consider in making that decision?” or “Were there other options you considered and discarded?” Listening carefully allows you to understand the learner’s clinical reasoning and to find deficits in his or her knowledge base. For a reluctant or resistant learner, you may find further elaborations helpful.⁵ Questions like, “If this patient was pregnant, would it alter your management?” or “What are your thoughts on the risks and benefits of empirical treatment as opposed to obtaining a definitive diagnosis first?” can bring out the learner’s thinking and knowledge.

Teach General Rules

Every case has teaching value, and your goal is to target your teaching appropriately. Once you understand what the learner knows, you are in a position to teach one or more general rules, which are targeted to the current case but also generalize to other, similar cases. For example, “It is well established that ACE inhibitors reduce morbidity and prolong life in patients with dilated cardiomyopathy” is more appropriate than “This patient needs captopril.” Your general rules might summarize anything from the key features of a particular diagnosis, the management of a demanding patient, or effective use of phone consultation.

A common problem for new teachers is trying to teach everything on one case. Learners cannot integrate more than a few general rules per case, so focus on the important areas for them and the patient. Avoid the temptation to focus primarily on what you know best. Also, learners with little knowledge

in an important clinical area, where their commitment is a blind guess and they offer no supporting evidence, may need more than a quick “sound bite.” If time allows, a mini-lecture may be useful, or you may need to assign reading or plan a review session with the learner in the future. In a busy clinic, the most helpful general rules may be just how to get through the day.

Reinforce What Was Done Right/Correct Mistakes

The final two steps of the teaching conversation are verbally reinforcing those behaviors that were highly effective and suggesting new behaviors that may be helpful in the future. As with all feedback, it should be well timed, expected, case specific, and behavior focused and utilize descriptive rather than evaluative language.⁶

Since we all learn most from the mistakes we identify ourselves, one strategy is to ask the learners to identify what they did right and what they would like to do better. Another is to ask learners in advance how they like to get feedback. This lets them know they will be getting feedback and invites their participation in the process.

Another variation is to give some positive feedback early in the teaching conversation, before probing for supporting evidence, to reduce learner performance anxiety. If you find you are never getting to the feedback steps as you work together, try setting aside a specific time for feedback (for example, after all observed encounters or observed procedures), allowing teacher and learner to sit down and discuss “how it went in there.”

In summary, the One-minute Preceptor model continues to provide a reliable framework on which good teaching conversations can be built. The model is most helpful when it is not viewed as static and rigid but as a pliable set of guidelines that can

be shuffled and altered as the ever-changing teaching situation warrants. You can acquire these microskills yourself with practice and reflection on your own teaching encounters.

Corresponding Author: Address correspondence to Dr Neher, Valley Medical Center Family Practice Residency, 3915 Talbot Road South, Suite #401, Renton, WA 98055. 425-656-4287. Fax: 425-656-5395. jneher@vmc.fammed.washington.edu.

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