PRECEPTOR SERIES:

Transforming a Teachable Moment

A Review of the One-Minute Preceptor

by Catherine M. Lea, BSPharm, BCACP and Kathryn R. Taylor, PharmD

Editors Note: *This article is the first installment of tehe Preceptor Series. These articles are meant to be digestible reviews with suggestions for advancing your experiential teaching. If you are interested in contibuting to this series please email thejournal@pswi.org.*

Take a minute to think back on your training as a pharmacy student. Remember the preceptor who gave you the confidence to question a prescriber without a shred of self-doubt? Remember the preceptor who barely noticed you except when there was a patient waiting for consultation? Chances are you can still recall the most inspiring and the most inattentive preceptors you had, regardless of how much time has passed since your training. The reality is that preceptors make a significant impact on students and residents. The challenge is to create a learning experience that will identify their opportunities for improvement and maximize their clinical skills.

Enthusiasm for teaching and an awareness of the learner's gaps in knowledge may not be enough to create an environment that ignites self-directed learning. Teaching moments can still occur under time constraints in a busy, patient-centered practice, so maximizing the impact of each encounter is important. Following a simple model with every interaction can help preceptors achieve their teaching goals. Neher introduced a five-step model of clinical teaching that focuses on simple behaviors called "microskills," commonly known as the One-minute Preceptor.[1] The microskills are designed to guide the teaching experience in 5 minutes or less; which is ideal in a busy clinical environment. The One-minute Preceptor model has been shown to improve students' perceptions of teaching skills and is generally well received by preceptors.[2]

The Five "Microskills"

The five microskills of the teaching model are (1) get a commitment, (2) probe for supporting evidence, (3) teach general rules, (4) reinforce what was done right, and (5) correct mistakes.[1] Table 1 outlines these five steps and gives examples of each. The sequence reveals the learners knowledge base and processing skills, exposes gaps, and guides teaching by offering immediate and specific feedback.[1,3,4]

Get a Commitment

The first microskill is generally applied after the encounter with the patient when the learner begins to process all the information that was gathered. Getting a commitment from the learner may begin with asking "What do you think is going on with this patient?" Traditionally learners have been trained to never guess the answer and may be reluctant to commit. Preceptor encouragement to more openly share their thinking process is important. Allow the learner time to make a final decision without taking over and directing them to the right answer. It's reasonable to offer guidance by asking "What else did you notice?" or asking about an objective measure, like blood pressure. For more targeted patient problems, example questions may include: "What laboratory tests do you think are needed?" or "Why do you think this is happening?"

Probe for Supporting Evidence

The next microskill allows the preceptor to gain insight into the learner's knowledge and ability to connect important clinical concepts.[3] Two common questions to probe for evidence include: "What factors led to this conclusion?" and "What else did you consider and then discard?" The first two steps of the model allow the learner to reveal what they know and what they still need to know about the particular case. This can be very revealing to the learner and may motivate them to engage in self-directed learning after the encounter.[3]

Teach General Rules

Once the learner has revealed all the information they are willing to share, the next microskill is teaching the general rules of the clinical decisions. The preceptor can now quickly focus on a few important clinical pearls that may have been applied in the first two steps. For example, "High-intensity statin therapy may be indicated in diabetic patients between the ages of 40-75 years, with an LDL cholesterol between 70-189mg/dl, and a calculated 10-year risk of atherosclerotic cardiovascular disease > 7.5%" is a more appropriate general rule than "This patient needs a high-intensity statin." The general rule can be applied to similar patients and extends beyond today's encounter. Rules that apply to clinical decisions should be evidence-based, but you may also share pearls such as what resources are available in your practice area. One example of this is "Our best resource for initiating a switch from warfarin to a target-specific oral anticoagulant is the Anticoagulation Service pharmacist."

Reinforce What Was Done Right

Learners crave feedback that is timely and specific, but giving feedback can be challenging in a busy work environment. The last two microskills target feedback

TABLE 1. The Five-Step "Microskills" Model of Clinical Teaching[1]

Microskill	Behavior	Example
Get a commitment	Learner identifies medication-related problems and plan to resolve them	• "What do you think is going on with this patient?" • "Why do you think this is happening?" • "What would you like to do for this patient?"
Probe for supporting evidence	Preceptor evaluates learner's knowledge or reasoning	• "What factors led to this conclusion?" • "What else did you consider, and then discard?"
Teach general rules	Teach common "take-home points" that can be used on future cases	• "High-intensity statin therapy may be indicated in diabetic patients between the ages of 40-75 years, with an LDL cholesterol between 70-189mg/dl, and a calculated 10-year risk of atherosclerotic cardiovascular disease > 7.5%"
Reinforce what was done right	Give feedback on specific behavior that benefited patient, colleagues, or clinic that should be repeated	• "I noticed you considered the cost of each medication before selecting your final therapy. Your attention to the patient's financial situation may improve adherence"
Correct mistakes	Give feedback on specific behaviors that need improvement. Select an appropriate time and place; be tactful	• "You could be right about your assessment, but without considering the patient's renal function, you may be recommending a therapy that could cause additional harm."

that will reinforce the learner's skills and reduce future errors. Examples of reinforcing what was done right include: "It was important that you considered the cost of the high-intensity statin choices before making the final selection" or "I noticed that you made a dose adjustment for age and creatinine clearance when selecting the dose and interval for this therapy." These examples reinforce the correct choices made by the learner and make it more likely that they will continue to use this knowledge on future cases.

Correct Mistakes

Correcting mistakes is generally the most challenging microskill for preceptors to use effectively. A mistake can create tension or may harm the patient if not corrected, leaving the preceptor with no choice but to take over the case. In order for learners to take full advantage of feedback that includes correcting mistakes, it should be scheduled, given privately, be specific to the case, and focus on a behavior that led to the mistake.[3] In some cases, it may be most appropriate to simply ask "What would you do differently next time?" A more specific example might be "A high-intensity statin may be a good choice for this diabetic patient based on your initial assessment and use of the risk calculator. But without fully evaluating the patient's other diagnoses, like their severe kidney disease, you could be making an inappropriate recommendation and putting the patient at greater risk. Try to include a full review of the patient's disease states before recommending statin therapy."

An effective strategy for using the last two microskills may be to end the conversation with a final behavior that the learner did well. With this method, you can encourage continuous learning without focusing only on mistakes.

From the Literature

Perceptions of the One-minute Preceptor model were compared to a traditional precepting model among medical students; and explored what teaching points students wanted to receive during a teaching session.[4] The study concluded that although students desired the same teaching points in both models, they preferred the One-minute Preceptor model.

In another study, medical students were given a survey to rate the teaching skills of internal medicine residents. The residents were then divided into two groups, one that participated in a 1-hour microskills training session and another that did not. Using the same survey to measure any change, the results showed that the residents who used the One-minute preceptor model had a statistically significant improvement in teaching skills.[2] The greatest impacts of the workshop were reported in the domains "asking for a commitment", "providing feedback", and "motivating me to do outside reading." Students reported they were more involved in decision-making, and felt the preceptor evaluated their knowledge and offered suggestions for improvement. In practice, lack of feedback is a common student complaint. Using the One-minute Preceptor model may help

preceptors overcome that challenge.

Developing the five-step microskills that make up the One-minute Preceptor model of clinical teaching requires continuous attention and practice. Of note, preceptors struggled with "teaching general rules" with little training or practice.[2] This microskill may require more clinical experience before application in a teaching environment. Overall, with practice, the five-step microskills can be adapted to almost any pharmacist teaching experience and can transform good preceptors who teach learners, into great preceptors, who ignite learners. ●

Catherine Lea is the PGY1 residency program director, regional coordinator and medication therapy management pharmacist at Mayo Clinic Health System, Eau Claire, WI. Kathryn Taylor is a student coordinator, medication therapy management and staff pharmacist at Mayo Clinic Health System Pharmacy & Home Medical, Eau Claire, WI.

References
1.   Neher JO, Gordon KC, Meyer B, Stevens N. A five-step "microskills" model of clinical teaching. J Am Board Fam Pract. 1992;5:419-424.
2.   Furney SL, Orsini AN, Orsetti KE, et al. Teaching the One-minute Preceptor: A randomized controlled trial. J Gen Intern Med. 2001;16:620-624.
3.   Neher JO, Stevens NG. The One-minute Preceptor: shaping the teaching conversation. Fam Med. 2003;35(6):391-393.
4.   Teharani A, O'Sullivan P, Aagaard EM, et al. Student perceptions of the one minute preceptor and traditional preceptor models. Medical Teacher. 2007;29(4):323-327.