Revisiting "The One-Minute Preceptor"

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Whether our individual role is primarily that of clinician, educator, administrator, or student, all of us probably have had first-hand experience of precepting students and young colleagues and are appreciative of the unique learning situation that such apprenticeship arrangements offer, while also being mindful of the considerable challenges. In a recent informal survey of community preceptors conducted at my own institution, preceptors clearly indicated that their main motivation for precepting is their enjoyment of teaching and the chance to work with students and give something back to the profession. However, with clinicians in patient care settings being continually pressed for time, tension often exists between efficiently caring for patients and allowing enough time to teach students and residents in busy clinical practices.

To address some of these challenges, the one-minute preceptor (OMP) model was initially developed as a way to assess and care for a patient's needs while also promoting effective learning by students in the clinical setting (Neher & Stevens, 2003). Building on the more traditional model of case presentations and extensive discussion, the OMP model promotes a method of offering guidance, instruction, and feedback to students in an efficient way and within the larger, busy clinical context.

The OMP model essentially proposes five microskills for preceptors to implement after a clinical student presents a case:

1. Get a commitment from the learner about his or her impression of the case; for example, you might ask, "What do you think is going on?" or "What do you want to do?"
2. Probe for underlying reasoning to explore the learner's understanding; for example, you might ask, "What led you to that conclusion?"
3. Teach general rules pertaining to the case; for example, tell the student, "When this happens, do this."
4. Provide positive feedback about what the learner did correctly using descriptive and not evaluative language; for example, tell the student, "Specifically, you did an excellent job of…."
5. Correct the learner's errors and make recommendations for improvement; for example, tell the student, "The next time this happens, try this."

The OMP model is not intended to be a static, rigid process but rather is meant to be a flexible set of guidelines that can be altered as needed according to the clinical situation.

Particular advantages of the model are that it fosters learner ownership of the clinical problem and allows the preceptor and learner to identify gaps in the learner's knowledge base in a nonthreatening way. In addition, the model allows for the provision of feedback that is timely, expected, case specific, and focused on behavior.

The OMP model also guides the preceptor in teaching one or more important rules specific to the current case but that may be generalizable to other similar cases. In general, it is usually best not to try to teach everything using one case and to remember that learners usually cannot integrate more than a few new general rules or points per case.

Since the description of the OMP model first appeared in the family practice literature, it has been well received by students and faculty alike (Teherani, O'Sullivan, Aagaard, Morrison, & Irby, 2007). Overall, the OMP model has provided a valuable and reliable framework for building effective preceptor-student conversations in a busy practice. As a

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student-oriented, patient-centered method that helps make student learning needs visible for teaching purposes, it is a model worth implementing to enhance satisfactory clinical experiences for preceptors, students, and patients.

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