

The One Minute Preceptor: A Vital Tool During COVID-19

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Abstract

The One Minute Preceptor (OMP) model of teaching has an important role to play during the COVID-19 pandemic. It's quick and easy to learn and can be applied to any clinical setting. By responding directly to a student's needs, and building on the knowledge they already hold, the OMP is able to offer relevant and opportunistic teaching that the learner can immediately apply. Finally, the OMP can be taught in under two hours meaning medical staff not used to regularly teaching can develop the confidence to offer high quality educational interventions.

Health services have witnessed unprecedented changes to their organisation and structure to manage the increased demand posed by the 2019 novel coronavirus (COVID-19). This has had a significant impact on the delivery of medical education and has forced institutions and educators to adapt to a new environment. Traditional classroom-based teaching has struggled to conform to social distancing rules, precipitating a transition to online learning. Whilst trainees value online learning resources¹ there remains a necessity to continue face-to-face teaching in clinical settings.

Junior doctors are being re-deployed to work within different teams in new, unfamiliar working environments. As a result, defined teaching time has become a scarce commodity. Under such conditions, the need for high quality clinical teaching is more important than ever before. The One Minute Preceptor (OMP) model² allows any grade of doctor to deliver rich learning opportunities in a wide variety of clinical environments.

The OMP model consists of five microskills of teaching, illustrated here:

1. Get a commitment from the learner:

- "Why do you think the patient has upper abdominal pain?"
- "I suspect the patient is suffering from pancreatitis or cholecystitis"

2. Probe for the learner's understanding:

- "What features of the history, examination and lab results support that?"
- "The patient has had two days of upper abdominal pain radiating to his back and he's vomiting. He's guarding in the epigastrium and has a raised Amylase and inflammatory markers"

3. Teach a general rule:

- "There are a number of causes of raised Amylase, including pancreatitis. In a patient with upper abdominal pain and guarding it's important to consider a perforated viscus as this can cause a raised Amylase"

4. Reinforce what was done right:

- "You were able to correlate the patient's history, examination findings and blood results to give appropriate differential diagnoses"

5. Correct any errors:

- "It's always important to consider a perforated viscus in these patients. An erect chest X-ray is a useful investigation to begin with"

These microskills allow the teaching encounter to focus on the problem-solving process used by the learner. By making a commitment the learner begins to process the information they've gathered about a patient and feel responsible for their care. This begins to expose their thought process making way for the teacher to probe the learner's understanding and identify what they do and don't know. Gaps in the learner's knowledge can be addressed by teaching a general rule. Complementing what was done well reinforces specific skills or behaviours and will build confidence for the learner to repeat these in the future. Correcting the learner's mistakes can be fraught with difficulties if not handled sensitively. If the learner is aware of a problem, this microskill affords the opportunity to acknowledge it. If, however, they're unaware of their mistakes it's appropriate for the

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teacher to discuss what was wrong and importantly, how to correct it in the future.

The OMP lends itself to providing immediate, relevant learning in a busy clinical environment by combining the identification of ‘learning needs’ with the management of real clinical cases. The concept of liminality is where the learner experiences feelings of uncertainty or anxiety when faced with unfamiliar problems.³ The OMP acts as a ‘scaffold’ for the educator to structure the learning process and to build on existing knowledge. Doctors redeployed to new clinical areas will experience this sense of liminality frequently and the OMP is ideally suited to capitalise on this opportunity for learning.

This model offers the unique benefit of serving as a short conversation to build on the knowledge already held by a learner.⁴ The learner can be anyone, and is not limited by seniority, specialty, or profession. When using the OMP, the learner articulates their understanding of the case and allows the educator to “diagnose” their learning needs⁴ and offer relevant, opportunistic teaching that the learner can immediately apply.

The OMP can be effectively applied to a wide range of clinical situations, for example, during a ward round or whilst donning or doffing protective equipment. It ensures teaching is focussed on a single learner, and not a group as is commonplace

with typical ‘bedside teaching’ techniques. To have a simple, versatile teaching tool that can be used ‘on the run’ is key to ensure essential teaching is provided.

Finally, this teaching model is quick and easy to learn and can be taught in under two hours.² This provides medical staff not used to regularly teaching the confidence to offer high quality educational interventions. It often remains a professional requirement in most healthcare organisations to contribute to teaching and training. This easy to learn, highly versatile tool can empower this process.

Whilst the OMP can’t replace the conventional teaching delivered in groups by the bedside or in the classroom, it has a role to play during this pandemic and can complement traditional teaching models into the future.

Ethical Approval

Ethical approval was deemed not to be required for this study

Competing Interests

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References

1. Goh J, Clapham M. Attitude to e-learning among newly qualified doctors. *Clin Teach*. 2014;**11**(1):20–23. doi:10.1111/tct.12117
2. Neher JO, Gordon KC, Meyer B, Stevens N. A five-step “microskills” model of clinical teaching. *J Am Board Fam Pract*. 1992;**5**(4):419–424. doi:10.3122/jabfm.5.4.419
3. Taylor DCM, Hamdy H. Adult learning theories: Implications for learning and teaching in medical education: AMEE Guide No. 83. *Med Teach*. 2013;**35**(11). doi:10.3109/0142159X.2013.828153
4. Farrell SE, Hopson LR, Wolff M, Hemphill RR, Santen SA. What’s the Evidence: A Review of the One-Minute Preceptor Model of Clinical Teaching and Implications for Teaching in the Emergency Department. *J Emerg Med*. 2016;**51**(3):278–283. doi:10.1016/j.jemermed.2016.05.007a