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Teaching Clinical Precepting: A Faculty Development Workshop Using Role-Play

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Abstract

Introduction: Precepting is when a medical educator listens to a learner's presentation and must teach and assess the learner while rendering safe patient care. A popular framework for this type of educational encounter is the one-minute preceptor model, which can work for learners at all skill levels. This workshop was created to develop skills of all teaching faculty, regardless of medical specialty, in precepting.

Methods: The workshop is based on Kolb's experiential learning theory. A PowerPoint presentation delivers the core abstract concepts. The PowerPoint allows for discussion of participants' prior precepting experiences, including both challenges and successes. The workshop ends with role-plays for participants to practice their skills and a facilitated debrief to aid individual reflection. Twelve role-plays were created for use in the workshop; these were then reviewed by someone in the matching specialty to enhance authenticity. Participants completed a survey after the workshop to evaluate the session. **Results:** This presentation was delivered 26 times to 392 participants at 16 different teaching hospitals. Twenty-one different medical specialties and subspecialties were represented. Ninety-seven percent of participants stated they would use the information presented in the workshop often or daily. There were conflicting comments about the role-plays. The negative comments centered around (a) personal difficulty participating in the role-plays and (b) the role-plays not being related to the learning. **Discussion:** Discussion and role-play can be an effective way to instruct educators in use of the one-minute preceptor as a framework for teaching.

Keywords

Clinical Teaching, Role Playing, Five Microskills, Role-Play, One-Minute Preceptor

Educational Objectives

By the end of this session, learners will be able to:

1. Describe the purpose of precepting.
2. Review the evidence supporting precepting using the one-minute preceptor.
3. Identify pitfalls faculty make when precepting.
4. Describe the components of the one-minute preceptor with examples.
5. Demonstrate the one-minute preceptor and reflect on personal performance.

Introduction

Precepting has been described as a method of teaching the medical learner for decades. It is a short encounter that requires the teacher not only to assess the learner's capability but also to teach the learner at his or her individual level while simultaneously ensuring safe, high-quality patient care. Traditionally, this type of teaching was used in the primary care specialties. Taking a broader definition of precepting—listening to a patient case from a learner without initially examining the patient—many specialties do precepting and could benefit from formal training in the five microskills.¹ The five microskills, the basis of the one-minute preceptor, were originally described in 1992 as a framework to perform precepting in a methodical, focused, and efficient manner. 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. In their original article, Neher, Gordon, Meyer, and Stevens not only described the five microskills but also reported on a related faculty development program incorporating them. The authors demonstrated that

Appendices

- A. Teacher Instructions.docx
- B. Precepting PowerPoint.pptx
- C. Anesthesia Precepting Role-Play.docx
- D. Emergency Med Precepting Role-Play.docx
- E. FM or IM Precepting Role-Play 1.docx
- F. FM or IM Precepting Role-Play 2.docx
- G. Neurology Precepting Role-Play 1.docx
- H. Neurology Precepting Role-Play 2.docx
- I. OB Precepting Role-Play .docx
- J. Pediatric Precepting Role-Play 1.docx
- K. Pediatric Precepting Role-Play 2.docx
- L. Psychiatry Precepting Role-Play.docx
- M. Surgery Precepting Role-Play 1.docx
- N. Surgery Precepting Role-Play 2.docx
- O. End-of-Session Evaluation .docx

All appendices are peer reviewed as integral parts of the Original Publication.

90% of faculty retained and used these concepts as much as 4 years after their initial training, based on self-report.¹

Irby and Wilkerson stated that “the most widely known and researched teaching method is the ‘one-minute preceptor model.’”² Medical students prefer the one-minute preceptor framework versus traditional precepting.³ Studies looking at preceptors who learned the five microskills and their students include Furney and colleagues’ study of internal medicine residents and their medical student learners⁴ and Eckstrom, Homer, and Bowen’s study of internal medicine faculty and their resident learners.⁵ In both studies, there were improvements in the preceptors’ self-assessments. The learners in both studies rated the preceptors’ skills higher after formal training, even though the ratings did not always reach statistical significance.^{4,5} Use of this framework can increase the number of specific feedback comments and teaching points given to the learner.^{6,7}

Kolb’s experiential learning theory was the underpinning of this workshop.⁸ The objectives combined with the chosen theory informed the choice of educational strategies. The educational strategies chosen for this faculty development workshop were a combination of didactics, discussion, and role-play. The workshop took the deliberate approach of having the faculty initially discuss their prior experiences precepting, guiding them in reflection on personal challenges both as learner and as preceptor. The five microskills framework was taught as an abstract concept with its supporting evidence, followed by the participants developing a plan that would be practiced immediately, corresponding to Kolb’s active experimentation. Role-play was chosen as the strategy to allow the participants the active demonstration required to fulfill the overarching objectives.

Discussion is utilized as an active learning strategy early on in the workshop in order to have the learners together generate potential challenges in the precepting encounter and could also enhance the learners’ motivation to improve their skills. Discussion has been described in many curricula developed for improving precepting skills, varying from general question-and-answer sessions unscribed by the facilitator² to planned discussion following specific video scenarios of precepting encounters.⁹ Either way, discussion as an active learning method has been used to teach faculty many skills, including the one-minute preceptor.^{1,3,4,9}

Hands-on practice of the one-minute preceptor in faculty development has been discussed in other curricula. Observation of these skills has been described as part of a curriculum for the one-minute preceptor.⁹ Looking at the top of Miller’s clinical assessment pyramid, observation documents what a teacher actually does when putting performance into practice.¹⁰ However, observation was not feasible in this context. Therefore, role-play was chosen as a way to simulate the workplace, which is the “shows how” level on Miller’s pyramid. Role-play has previously been used for teaching the one-minute preceptor, with other faculty³ and standardized learners⁴ playing the role of learner; both strategies have been shown to promote changes in faculty perceptions.

Role-plays have been used in various levels of education and noted in medical education since Simpson’s article in 1985.^{9,11} Role-plays have multiple benefits for the learner including practicing a skill, reflecting on performance, and understanding the perspectives of others through a more realistic training scenario.⁹ In this workshop, those others would be our learners: medical students and residents. In faculty development, role-plays have been used face-to-face and online and can improve individual faculty self-assessment of teaching behaviors.¹¹⁻¹³ Role-play requires planning, teacher flexibility, and comfort with potential loss of control of the learning environment. To achieve maximal individual learning while collating the principles all learners have experienced takes attention to key elements. Effective role-plays have clear objectives, a set time limit, and methodical debriefing to maximize reflection in learning.¹⁴ Some element of scripting that can make the person playing a role more comfortable while ensuring that objectives are met may be helpful.

There are other teaching materials in *MedEdPORTAL* regarding ambulatory teaching strategies, some of which have the five microskills embedded in larger sessions. One publication specific to precepting uses role-play.¹⁵ Our workshop adds to the literature by featuring role-plays that are more realistic and by including facilitated debriefing. The role-plays here are more scripted, have additional details for the learner to use in answering the preceptor's questions, and have been deliberately written to bring out common preceptor pitfalls. The different role-plays allow faculty to choose the content most realistic for everyday teaching of particular attendees. All of these characteristics create a more standardized educational method. There are 12 role-plays in this publication, representing nine medical specialties including the six medical school core clerkships.

Methods

Workshop Sign-Up

This resource was offered as an open workshop. Instructions on how to run the workshop can be found in Appendix A. Even though we offered advance sign-ups for several weeks ahead of time, anyone could attend without prior registration. Advance sign-up allowed the facilitator to prepare appropriate types and numbers of role-plays for those attending. A week in advance, a list of participants was reviewed to ensure the facilitator would have appropriate examples to use throughout the discussion. Additionally, the facilitator could plan ahead for grouping of the participants during the role-play. There were no prerequisites for the learners to attend the workshop. The workshop can be done with a variety of specialties or within a single medical specialty. We did not define an ideal size. The workshop has had from six to 62 participants. It can be done with a mix of resident and staff physicians.

Workshop Room Setup

The best room had chairs that could be moved. This allowed participants to move appropriately during the role-plays. It was ideal to have a computer with the capability of showing the slides. In the event the equipment did not work properly, the workshop was given with a whiteboard, using hard copies of the slides as handouts for the participants.

Didactic Presentation

The initial part of the session was the core didactics with description of the one-minute preceptor and examples of how to perform the five microskills (Appendix B). The slides had straightforward principles that were uncomplicated to present. During the didactic section, examples were given of each of the core concepts to enable the learners to think about ways to experiment in the future. The introduction and core principles with discussion took approximately 30 minutes.

The creation of the slide deck and framework of the five microskills was straightforward. The difficulty of the didactic portion was being aware of which specialties were represented in the audience. The facilitator had to have examples ready for any type of participant, whether resident or experienced faculty, and for any specialty. Facilitation was easier if the facilitator had significant experience precepting learners at different skill levels, from medical students to fellows. A small number of faculty were trained at the sites of this session to be facilitators at local hospitals. Our experience training these faculty was that creating precepting examples in advance allowed the facilitators to more comfortably engage participants from a different specialty.

Discussion

Facilitated discussion occurred throughout the workshop. The objective of the early part of the didactic portion was to have the participants reflect on their personal experiences with precepting as a learner and as a preceptor. A key factor was to create a safe learning environment where all challenges could be discussed in a nonjudgmental manner. As the five microskills were being defined, the discussion included examples of how to perform them using the specialties represented in the audience. Discussion continued after the role-play as well.

Role-Play

Each role-play used in the curriculum was designed with the objective of having the teacher practicing the five microskills work on the typical pitfalls of interrupting, asking too many first-order questions, potentially giving the learner the answer through a mini-lecture, and ending the encounter with no feedback. Each role-play was reviewed with a physician in the named specialty for content accuracy and environmental realism. The number of role-plays created allowed participants to precept a learner with a presentation that was more relatable to their daily life than pretending to be another specialty. The oral presentation was deliberately scripted to create common preceptor pitfalls.

A critical step was setting up the role-play. The participants were placed in groups of two. The facilitator passed out a single role-play to each group (Appendices C-N). Only the person playing the learner role got the actual case to read. The facilitator explained the time limit of 10 minutes, which started after the learner had time to read the role-play.

The workshop has the option to perform two role-plays instead of just one in order to give all participants an opportunity to practice. The facilitator must be certain that the group has two different medical specialties represented, unless the group's single specialty is one of those with multiple role-plays (i.e., Appendices E-F, G-H, J-K, or M-N).

Debriefing the Role-Play

At the conclusion of the role-play, the facilitator posed the questions written in the teacher's instructions (Appendix A). The debriefing questions aligned with the skills of the one-minute preceptor and the common faculty pitfalls. Both preceptor and learner received questions during the debrief. For example, the facilitator asked the learner, "Did the faculty interrupt you?" and asked the teacher, "How long did you wait to start asking questions?" These questions were two perspectives on the same issue.

At the end of the workshop, a short written evaluation (Appendix O) including two Likert-scale questions and two open-ended questions was completed by participants. The survey had only two quantitative questions because it was part of a larger program evaluation rather than concentrating on just the precepting workshop. The comments were collated by our program manager. The quantitative data were analyzed with simple statistics, and the qualitative comments were analyzed by a group of three faculty development physicians who grouped like comments together and analyzed them as a whole.

Results

This presentation was delivered 26 times at 16 different teaching hospitals in the Military Health System. Three hundred and ninety-two learners participated in this material. Residents and staff physicians, 98 and 294, respectively, from 21 medical specialties and subspecialties attended. Forty-eight percent were family medicine, internal medicine, or pediatrics. Surgical specialties such as orthopedics, ear-nose-throat, and anesthesia made up 14% of the total attendees. Other specialists, including emergency medicine, psychiatry, radiology, and dermatology, also attended in small numbers. Seven percent of attendees did not categorize their specialty. The experience of the participants ranged from novice preceptors, as in junior residents and faculty in the first year after residency, to faculty and residency program directors with more than a decade of experience.

Quantitatively, 97% of people felt this material would be directly useful to them either daily or often. Ninety-six percent of the participants felt that the material was either "very organized, added to my teaching/research skills," or "mostly organized, several items useful."

Qualitatively, participants commented on the role-play. Comments were nearly equally divided between those who liked and those who did not like the role-play. There were numerous comments about how helpful the role-play was for working on the skills taught. Learners also commented on how helpful it was to frankly discuss struggles with precepting while attempting difficult examples as a way to enhance their

own skills. Even though approximately half of the comments discussed not liking the role-play, none stated that the role-play did not aid learning; instead, those comments expressed more of a personal dislike of the method. As examples of the conflicting comments, one participant stated, “Small groups and discussion more helpful than role play,” and another participant stated, “I benefitted the most from actually practicing precepting. I think additional opportunities for this and less didactic time would have been helpful.” Other comments included the following:

- “Role playing in precepting was very good to see how tough it can be.”
- “I would like more time to do role playing, deconstructing examples of what we do already.”
- “Active/small-group work always dreaded, but is actually quite helpful and pertinent. Thank you!”
- “Role playing added little benefit, awkward and wasted time.”

There was no formal assessment of the participants. However, in the debrief, there was discussion of the person who played the preceptor and of the skills demonstrated.

Discussion

The current resource adds to prior work by offering more structured role-plays for multiple specialties. The lack of deliberate role-play cases with instructions, including structured debrief questions, limits many faculty development programs’ ability to use this teaching strategy. Our workshop also deliberately applies the concept of precepting to specialties outside of the primary care specialties. Additionally, the workshop has been given numerous times in tertiary hospitals and community hospitals with participants of various specialties. This has allowed for a robust facilitation experience with opportunities for more sharing of ideas and challenges that junior faculty or residents have not previously encountered.

One consideration while facilitating the didactic portion is ensuring the facilitator manages the discussion so as to allow time for the role-plays. There have been instances when the audience began discussing the emotions involved in precepting challenging learners and the facilitator needed to skillfully redirect the group with examples of using the five microskills with such learners. These can be learners who ramble without organization in case presentation, those who cannot create an accurate differential, or those who may guess the diagnosis but are unable to support it. Such struggles are best acknowledged and then integrated into the debrief of the role-play.

If the attendees are from only one department and one discipline, it will be easier for the facilitator to prepare for possible discussion questions. A common challenge for the facilitator presenting the workshop to one discipline is the potential for the discussion to turn to medical care rather than focusing on the five microskills. The facilitator needs to redirect any medical care discussion back to the five microskills and learner-centered teaching.

A difficult aspect of this presentation has been ensuring there are realistic role-plays. The faculty then can reflect firsthand on how precepting can be done in their specific teaching roles. This enables faculty to understand the five microskills on an everyday basis.

Reflecting after facilitating and observing numerous sessions, we believe there is no ideal number of attendees. Having less than six participants seems to limit role-play debriefing since it will be related to fewer simulations. A group of more than 20 takes extra planning in order to have enough space and enough copies of the role-plays of the appropriate specialty. Additionally, large groups require a more experienced facilitator. As the group of participants becomes more varied in specialty and experience level, the facilitation skills of the presenter need to be sharpened.

Over the past years and dozens of workshops, the largest changes have been in managing the role-play and the debrief. It is helpful for the facilitator, especially if there has been no preregistration, to get a firm idea of who is in the audience. As the material has been delivered, examples of precepting struggles have been accumulated from the attendees and used in future sessions. Many of these examples are included

here in the notes portion of the slide presentation (Appendix B). Participants have made verbal comments in real time about how helpful having a realistic example is for their individual learning. Getting buy-in from the variety of specialties as to how the one-minute preceptor framework can be more efficient requires the facilitator to be adaptable when demonstrating the microskills. The time allowed to set up the role-play and debrief has changed over the sessions. Initially, the workshop was 50-60 minutes. However, there was confusion while the learners were getting ready for the role-play. The facilitator had challenges handing the correct roles out in a timely fashion as well. Once we built in 10 minutes to explain the activity and allow the person playing the learner to fully read the role, the actual role-play was smoother. Fully explaining the tasks also made the debrief more productive.

There are several limitations with this workshop, the first being the availability of enough specialty-specific role-plays. Participants, both learners and faculty, were a significant variable. Due to complicated schedules and last-minute changes, the facilitator never knew how many faculty would attend ahead of time. Second, and most important, was the makeup of the audience. The facilitator had to manage the large number of role-plays. Initially, having as many written as possible was difficult. Later, the main issue was having enough role-plays for each specialty depending on who attended. A third limitation was the evaluation. Since the workshop was part of a larger program, the evaluation was generic. The evaluation allowed for collation of attendee comments for multiple workshops while sacrificing specificity on the individual methodologies.

In summary, this teaching workshop on the one-minute preceptor has been well received by faculty and has evolved over time after reflection and feedback. Facilitation of this workshop requires advance planning but can maximize participants' learning through experience and observation.

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Ethical Approval

Reported as not applicable.

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