LMU-DCOM | Preceptor Development

# Introduction to Precepting

*Foundational Skills, Strategies, and Evidence for Teaching OMS-III and OMS-IV Students in the Clinical Setting*

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# Disclosures

*I have no conflicts to disclose, financial or otherwise.*

SECTION 1

# Learning Objectives

*By the end of this presentation, participants will be able to:*

1. Describe the multiple roles of the clinical preceptor and their impact on medical student development.
2. Apply evidence-based teaching microskills — including the One-Minute Preceptor and SNAPPS — within a busy clinical workflow.
3. Demonstrate effective feedback and direct-observation techniques using frameworks such as R2C2, Ask-Tell-Ask, and the Mini-CEX.
4. Identify strategies to establish psychological safety, set rotation expectations, and respond to struggling learners.
5. Implement high-yield, low-effort precepting behaviors that improve teaching quality without adding significant time burden.

PART ONE

# The Role and Identity of the Clinical Preceptor

*What it means to be a preceptor — and why it matters more than most physicians realize.*

# What Is a Clinical Preceptor?

A clinical preceptor is an experienced practitioner who supervises clinical practice AND deliberately facilitates the application of theory to practice in real patient-care settings.

### NOT just supervision

- Oversight without deliberate teaching
- Watching and signing notes
- "The student tagged along today"
- No structured feedback or assessment

### Deliberate teaching in context

- Patient safety AND learner development
- Intentional teaching moments
- Direct observation and feedback
- Role-modeling clinical reasoning

# The Many Hats a Preceptor Wears

### Teacher

Frames concepts; structures learning

### Role Model

Demonstrates the values of the profession

### Supervisor

Ensures patient safety; calibrates autonomy

### Assessor

Observes, evaluates, documents performance

### Coach

Helps the learner improve over time

### Mentor

Provides career guidance and support

### Advocate

Champions the learner inside the system

### Gatekeeper

Protects patients and the profession

*All eight are happening simultaneously — even when you are not consciously choosing one.*

# Why Preceptors Matter

## Evidence linking preceptor quality to student outcomes:

**Specialty choice**

Students exposed to enthusiastic, skilled primary care preceptors are significantly more likely to choose primary care careers.

**Professional identity**

Role models shape how learners come to see themselves as physicians — for better or worse.

**Clinical competence**

Direct observation and timely feedback are the strongest predictors of skill development on rotation.

> *"Students remember how a preceptor made them feel long after they have forgotten what was taught."*

The "hidden curriculum" is what is actually transmitted — through behavior, tone, and what gets attention.

DISCUSSION

# Think back to a preceptor who shaped how you practice medicine today.

*What did they do — specifically — that left a lasting impression on you?*

*Share in the chat or unmute when ready.*

PART TWO

# Understanding the Learner

*How adults learn, where OMS-III/IV students are developmentally, and why psychological safety changes everything.*

# How Adults Learn

Adult learners (andragogy — Knowles) bring assumptions that change how you should teach:

- **Need to know** Tell them why before how. Connect teaching to patient care decisions.
- **Self-direction** Ask what they want to work on. Negotiate goals, do not dictate.
- **Experience matters** They bring prior rotations, knowledge, and life experience. Build on it.
- **Problem-centered** Teach around real patients, not abstract topics.
- **Internal motivation** Tap into curiosity and competence — not grades and pressure.

# Where Your Student Is — Developmentally

*RIME framework — a practical way to locate your learner*

**R**

**Reporter**

Gathers and reports clinical data accurately

**I**

**Interpreter**

Organizes and interprets findings into a problem

**M**

**Manager**

Proposes management plans; considers options

**E**

**Educator**

Teaches others; identifies own learning gaps

**OMS-III:** typically Reporter → Interpreter. **OMS-IV:** Interpreter → Manager, residency-bound and seeking entrustment.

# Psychological Safety: The Precondition for Learning

*Students who feel unsafe will hide what they do not know. Students who feel safe will show you their gaps — and that is where teaching becomes possible.*

### Builds safety

- "I don't know — let's look it up."
- Asking the student's opinion first
- Naming uncertainty in your own thinking
- Welcoming questions and "stupid" questions
- Private correction; public encouragement

### Erodes safety

- Pimping with public humiliation as the goal
- Sarcasm or eye-rolling at wrong answers
- Saying "you should know this by now"
- Correction in front of patients or staff
- Withholding all feedback until evaluation

DISCUSSION

# What is one thing you do — or have seen done — that immediately puts a new student at ease on day one?

*Share in the chat — we will collect a few to compare.*

PART THREE

# Setting Up the Rotation for Success

*Day-one orientation, expectations, and the conversations that prevent end-of-rotation surprises.*

# Day-One Orientation: A 10-Minute Investment

*Cover these six items before you see the first patient together:*

1. **Logistics** Schedule, where to park, where the bathroom is, lunch.
2. **Schedule of the day** Clinic flow, OR start times, rounding patterns.
3. **Communication** How to reach you; what to do if you are with another patient.
4. **Expectations** How you want them to present, when to interrupt, what to read.
5. **Goal-setting** "What do you most want to get out of this rotation?"
6. **Feedback norms** "I will give you feedback after every patient and at mid-rotation."

# Sample Day-One Script

*A short, repeatable opening that sets the tone for the whole month:*

"Welcome. I am glad you are here this month.

**A few things up front so we start on the same page:**

1. I expect you to see patients independently and present them to me — start with a one-minute summary, then we will dig in.
2. I will give you feedback after every patient. Some will be quick. Some will be longer. None of it is personal — it is about your growth.
3. If you do not know something, say so. Saying 'I am not sure' is always the right answer — guessing is not.
4. I will watch you with patients several times this month. That is the only way I can really help you improve.

*Now — tell me what you most want to get out of this rotation."*

PART FOUR

# Teaching in a Busy Clinical Setting

*Microskills, frameworks, and time-tested techniques you can use in the next patient encounter.*

# The One-Minute Preceptor (OMP)

*Neher et al., 1992 — the most-taught and best-validated brief teaching framework in clinical education.*

1. **Get a commitment** *"What do you think is going on?"*
2. **Probe for evidence** *"What led you to that conclusion?"*
3. **Teach a general rule** *"In patients like this, remember that..."*
4. **Reinforce what was right** *"You did X well — keep doing that."*
5. **Correct mistakes** *"Next time, consider doing Y instead."*

# SNAPPS: A Learner-Driven Alternative

*Wolpaw et al. — flips the script: the student drives the case, you facilitate. Excellent for OMS-IV / sub-interns.*

**S** — **Summarize**

Briefly summarize the history and findings

**N** — **Narrow**

Narrow the differential to 2–3 possibilities

**A** — **Analyze**

Analyze the differential by comparing and contrasting

**P** — **Probe**

Probe the preceptor — ask about uncertainties

**P** — **Plan**

Plan management for the patient's issues

**S** — **Select**

Select a case-related issue for self-directed learning

# Teaching Tools You Can Use Today

**Activated demonstration** Before the encounter: "Watch how I do the cardiac exam — pay attention to when I auscultate." After: ask what they noticed.

**Think-aloud** Narrate your clinical reasoning out loud during the visit. "I am worried about X because Y — that is why I am asking about Z."

**Wait time** After a question, wait 3–5 silent seconds before stepping in. It is the single highest-yield free teaching technique.

**Priming and debriefing** Before: "While you see this patient, focus on...". After: "What did you find? What surprised you?"

**Teaching scripts** Develop 5–10 short, polished mini-lessons on conditions you see weekly. Repetition makes you efficient.

DISCUSSION

# Which of these techniques have you tried — and what has worked or fallen flat for you in your own clinical setting?

*We will hear from a few of you before moving on.*

PART FIVE

# Feedback, Observation, and Assessment

*The heart of clinical teaching — and the part most preceptors find hardest.*

# Direct Observation: The Underused Foundation

*Studies consistently show that medical students are directly observed performing a full clinical encounter fewer than 1–3 times across an entire third year. Without observation, evaluation is guesswork.*

**2**

**direct observations per week**

*is a realistic, evidence-supported goal*

**Two tools that make observation efficient:**

**Mini-CEX** — 15–20 min observation of one clinical encounter, structured rating, immediate feedback. Use 2–3× per rotation.

**DOPS** — same format for procedural skills (suturing, joint exam, OMT).

# What Makes Feedback Land

- ✓ **Specific** Behavior, not personality. "Your H&P missed asking about red flags" — not "you need to be more thorough."
- ✓ **Timely** Within minutes or hours — not at end of rotation. Memory fades; usefulness fades faster.
- ✓ **Observed** Based on what you saw — not what you assume happened.
- ✓ **Actionable** The student can do something differently tomorrow.
- ✓ **Two-way** Their interpretation matters. Ask before you tell.

# Ask-Tell-Ask: A Pocket Feedback Tool

*A 60-second feedback structure that works after almost any clinical encounter.*

## ASK

**Get their perspective first**

*"How did that go from your point of view?"*

*"What would you do differently next time?"*

## TELL

**Share your observation**

*"Here is what I noticed: you did X really well."*

*"The one thing I would change is Y."*

## ASK

**Check understanding and plan**

*"Does that match what you saw?"*

*"What will you do next time?"*

SARGEANT ET AL.

# R2C2: For Longer or Harder Feedback Conversations

*When you need more than 60 seconds — mid-rotation, end-of-rotation, or a difficult conversation.*

**R** **Relationship** Build rapport. Acknowledge effort. "I want this to be useful for you."

**R** **Reaction** Explore their reaction to the feedback they have received so far. "What stands out to you?"

**C** **Content** Confirm the content of the feedback together. "Here is what I have observed..."

**C** **Coaching** Coach them to a concrete next step. "What will you focus on for the second half?"

# Writing Narrative Comments That Actually Help

*The end-of-rotation narrative comment is the most enduring artifact of your teaching. Make it specific.*

### Weak

*"Has good attention to detail."*
*"Works well with the team."*
*"Will make a fine physician."*

**Why it fails:** generic; no behavioral evidence; cannot guide growth or document concerns.

### Strong

*"During rounds on a patient with new-onset CHF, the student independently identified a drug-drug interaction the team had missed and communicated it clearly to the attending."*

**Why it works:** specific behavior, specific context, observable, defensible.

DISCUSSION

# What makes a feedback conversation hard for you — the timing, the content, the student's reaction, or something else?

*We will compare a few experiences before moving on.*

PART SIX

# Workflow and Practical Realities

*Teaching alongside productivity, documentation, EMRs, and the rest of a real practice day.*

# Teaching Without Slowing Down

**Parallel charting** While student sees the next patient, you chart the last one. Teach in the hallway between.

**The two-minute teach** After each patient: one teaching point + one feedback point. Total: under 2 minutes.

**Wave or modified scheduling** Some preceptors block 1 longer slot midway to debrief multiple cases together.

**Use the team** Residents, nurses, MAs, and pharmacists can each teach the student something only they know.

**Student notes** Per 2018 CMS guidance, students' documentation can count toward billing if you verify it. Lean into this.

# When a Student Is Struggling

*Recognize early. Document. Communicate. Do not wait until the end of the rotation.*

### Common patterns

- Knowledge gaps inconsistent with year
- Disorganized clinical reasoning
- Defensiveness about feedback
- Withdrawing socially from the team
- Lateness, absences, missed assignments
- Signs of personal or mental health distress

### What to do

1. Name the concern, specifically and privately.
2. Ask — there may be a personal reason.
3. Set a concrete improvement goal.
4. Document what you observed and discussed.
5. Notify the clerkship director by mid-rotation — never at end.
6. Refer for wellness support; do not try to treat.

PART SEVEN

# Putting It All Together

*A practical model — and ten things you can start doing on Monday.*

# Six Domains of an Excellent Clinical Teacher

### Clinical competence

Models excellent reasoning; visibly humble about uncertainty.

### Teaching knowledge

Uses structured frameworks; varies strategy by level.

### Learner-centeredness

Assesses the learner before teaching; adapts to needs.

### Relational skill

Creates safety; shows interest in the learner as a person.

### Feedback & assessment

Specific, timely, observed; writes useful narratives.

### Professional role modeling

Demonstrates the values they want students to internalize.

# Ten High-Yield Behaviors — Start Monday

1. **Ask "What do you think?" before sharing your assessment.**
   *OMP step 1 — 5 seconds, transforms the encounter.*
2. **Wait 3–5 seconds after asking a question before answering it.**
   *Free; instantly improves response quality.*
3. **Give one specific positive + one specific growth area daily.**
   *"Today: your organization was excellent. Slow down the exam."*
4. **Use a clear day-one orientation script.**
   *10 minutes that prevents a month of confusion.*
5. **Directly observe the student with at least 2 patients per week.**
   *Required for valid feedback. Anchors the Mini-CEX.*

# Ten High-Yield Behaviors — Start Monday

6. **Write narrative comments with specific behavioral evidence.**
   *"On Thursday, identified a missed drug interaction" — not "good attention to detail."*
7. **Hold a private 15-minute mid-rotation conversation using Ask-Tell-Ask.**
   *Prevents end-of-rotation surprises.*
8. **Model intellectual humility: "I am not certain — let me look that up."**
   *The strongest thing a preceptor can say.*
9. **Use the end-of-day synthesis question.**
   *"What is the most important thing you learned today? What are you still confused about?"*
10. **Contact the clerkship director at mid-rotation if you have concerns.**
    *Early contact gives the student a chance to succeed.*

DISCUSSION

# Of the ten behaviors we just covered — which ONE will you commit to trying with your next student?

*Type a number in the chat — let us see where the energy is.*

# A Final Thought

*Clinical precepting is not an add-on to the practice of medicine. It is one of its most consequential acts.*

> *A ten-word framework for excellent precepting:*
>
> **Observe. Ask first. Teach the rule. Reinforce. Correct. Repeat.**

# Key sources cited in this presentation


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*Full reference list (44 sources) appears in the accompanying research report.*

THANK YOU

# Questions & Discussion

*Thank you for your time and your commitment to teaching the next generation of physicians. I welcome your questions, your reflections, and the experiences you bring to this work.*

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