10

Video supervision of medical students - how to facilitate a psychological safe learning environment

Mads Toft Kristensen

Department of Public Health
University of Copenhagen

Background

Communicating with patients is very central in the clinical work as a medical doctor. It is well known that many patient complaints are more about communicative problems than about medical matters. The teaching in patient communication at medical school is limited and most often simulated with patient actors. Video supervision with real patients only takes place in one course, which is the course ‘Family Medicine’ that is situated in the final year of medical school at the University of Copenhagen. I have taught this course around ten times within the past 6 years and have led the exam five times. As most other courses at medical school, ‘Family Medicine’ is mandatory. It consists of different elements: lectures, class-based teaching (SAU), and a clinical stay of eight days in a general practice, where the student conducts consultations with patients and must video record these consultations for the class-based teaching and the exam. The exam is individual and includes one of the student’s recorded videos. The student has to analyze the video both from a communicative perspective and from a medical perspective. The course description is as follows:

After the course, the student should be able to use prior knowledge in the meeting with a new patient and know and apply the patient centered consultation process. The student must include the patient in the decision process and act from the patient’s total life situation and prerequisites. The student must be able to diagnose and initiate treatment of common medical conditions in general practice.

Moreover, the student must apply the consultation process as a communicative tool for diagnosis and treatment.

Since the course is mandatory, the students do not choose it from personal interest or future application and it is doubtful that all students have read the course description beforehand. Due to the placement of the course in the last year of medical school, the students often have plans for their future profession, which begins within a few months – some have research plans, others plan to work clinically. Despite this, the students form a homogenous group, because all have followed the same curriculum of courses during the past 5 years. However, the students have diverse experiences with patients; some have worked as a health professional for some years as a spare time job, while others do not have other experience than the mandatory clinical stays.

The significance of interpersonal relationships between students and teacher is described in the textbook of the UP course (Horst & Ingerslev, 2015). These are hugely important for students throughout their education and can contribute to increased motivation. When giving feedback in video supervision, it is extremely important that you as the teacher establishes and enforces rules for good behaviour and tone and strives to make everyone feel comfortable. In my teaching, I make an effort to learn the students' names and spend my teaching breaks with the students to be present and to contribute to making the students feel welcome.

The good student-teacher relationship and confidence (safe learning environment) are most important in video supervision in order to enhance the formative element of feedback (Hsiang-Te Tsuei et al., 2019). At the beginning of the course, I therefore use quite some time on listening to the students' previous experiences with clinical work and communication. This helps to increase the learning outcomes, but also to know the students' competences and experiences that can be drawn into the teaching and increase the level of reflection in the group. The course has a very broad curriculum that could easily fill up the lessons and I have thought of using less time on asking about the previous experiences. However, during the UP course, I have reflected upon what activities affect the students learning outcomes, and I have decided to hold on to the sharing of experiences and be clearer about how to make it as relevant to intended learning outcomes as possible. The introductory experience sharing also serves to get to know the students better at an individual level and to create a psychological safer learning environment. During the course, I continuously invite the students to talk about their experiences from their clinical stay in general practice – I en-

courage them to talk about their difficulties, because I have experienced that there is much more to learn from talking about the challenges and by watching videos of consultations that are not perfect, neither communicatively nor medically. I also attempt to be open with my personal experiences of difficult clinical and communicative situations. I do this on purpose, because the video recordings can expose the students in sensible situations and therefore it is important that we can discuss these situations in a safe and respectful environment. Moreover, it is important for me to underline that as a medical doctor you have to work continuously with your patient communication skills.

Due to the limited time of class-based teaching and due to the importance for the learning outcomes, the aim of this development project is to facilitate the building of relations and confidence in group supervision of videos.

Method

I would like to know, what could be gained from getting a better overview of the students' experiences, expectations and possible worries and be better prepared for the first meeting with the students – to align expectations and meet the students' worries. it is most common that the teacher has no knowledge of the students before the first meeting. With five teaching sessions of four lessons each, there is relatively short time to get to know the students. Moreover, the video supervision is supposed to start on the first course day, so ideally the necessary feeling of a safe learning environment would be founded before the first teaching session.

The planned activity of this project was to formulate online open-ended questions about students' experiences, expectations and possible worries. These questions were sent to the students to answer prior to the first course day. The gained knowledge from the students should be the point of departure in the first lesson, where I as mentioned before spend some time on building up the relationship with and between the students. This is inspired by and in line with the textbook of the UP course that suggests teachers to actively include the students, and to establish a dialogue with students about their ideas and experiences (Johannsen et al., 2015).

The outcome of the activity is what the students answer to the online questions and how engaged their answers are. The answers were used throughout the course and at the end of the course, the students made a writ-

ten evaluation to explore how they experienced the teaching and the video supervision.

I was inspired by some of the steps in the patient section of the patient centered communication model in the course (appendix A) to formulate five open-ended questions – the questions are related to the students' understandings of patient communication, expectations to the course and eventual worries of video supervision. The open-ended questions were presented as a padlet and the students received a link one week before and a reminder two days before the first day of teaching. The five questions were as follows:

1. What experiences do you have with patient communication?
2. What can be difficult in patient communication?
3. Which expectations do you have to the clinical stay in general practice?
4. Which expectations do you have to the class based teaching?
5. What do you look forward to or worry about:
   a. the clinical stay?
   b. the class based teaching?

Results

Four out of ten students answered the online questions (see appendix B in Danish). The four students all had a relatively broad experience with patient communication, both from hospitals and from general practices. The students found that the difficult part of patient communication related to their own limited level of medical knowledge or experience. They also found that adapting their communication to different patients could be challenging, especially when patients had a very different background than themselves or if patients were dissatisfied or angry. In class, I asked why some students had not answered the padlet. The answers were that they had received very much information about the course and therefore the padlet was forgotten. Moreover, the students prioritized the arrangement of the clinical stay, because it was their major concern about passing the course.

The students had realistic expectations to the clinical stay and to the class based teaching. They were concerned about what to do with the patients, if they were not sure about the diagnosis or the diagnostic process.

One student was worried about the video supervision in the classroom, because 'it is never pleasant to watch yourself'.

At the first course day, I decided to interview each student as usual. Thereafter, I presented their answers from the padlet and we had a short discussion about how to handle clinical uncertainty, which is an ever-lasting challenge for medical doctors. The statements in the padlet became a common reference point and instead of being just a concern formulated by one student, the concern was legitimized as a general circumstance by means of the padlet. Throughout the course, we came back to this challenge and experienced how the students handled the clinical uncertainty in their videos. We also came back to the issues of adapting communication to different patients and what to do if patients are impatient or rude.

At the last course day, I conducted a written evaluation with open-ended questions. The questions were inspired by a well-known and very used evaluation form (so called LEARN) from the research training course of general practice. The questions were

1. What is the most important I have learned in the class?
2. What is still unclear to me?
3. What would I like to learn more about/improve?
4. What will I use in the future?
5. What has worked in the teaching?
6. What could be improved in the teaching?

Seven students answered the form. All students found that the communication part was important and useful in the future. Three students pointed out that the open, positive and relaxed atmosphere had worked very well. No students mentioned negative issues about video-supervision or feeling unsafe. Most students found that the most important they have learned and wanted to learn more about, was the communication. Two students focused more on the knowledge needed to pass the exam. No students commented directly on the use of the padlet before the beginning of the course.

Discussion

Only four out of ten students answered the padlet, however the answers were more detailed and open-hearted than I had expected. They were very

useful to draw into the teaching. In my class-based teaching, I usually deal with the issues that appeared in the padlet, but it was very satisfying as a teacher to refer to the students' own worries in order to increase the relevance. At one hand, it supported my idea of spending time on creating a psychological safe environment. At the other hand, it helped to focus more on the aspect of clinical uncertainty – and to have an ongoing discussion about this.

All four students, who responded the padlet, had broad experience from patient communication, and one could worry, that students with less experience would be reluctant to answer the padlet. However, the all students except from one had broad clinical experience. The non-responders told that they had forgotten to answer the padlet, because they receiver so much information at the beginning of the course and focused most on arranging their clinical stay in general practice. There was no resistance to the questions.

The written evaluation showed me that vast majority of the students found that the communication part had been the most important thing to learn. I think that my early focus on the safe learning environment facilitated the students to engage in discussions about communication.

Although only four out of ten students answered the padlet, it gave me as the teacher a chance to get to know the students better from an earlier point of the course, which was a great advantage. It also allowed me to be prepared for discussions – in the case of this course, the discussion of clinical uncertainty was new and very interesting. I am not sure how to improve the response rate of the padlet – of course, the padlet could have been answered at the first course day, but it would have used some time and would not have allowed me to have deeper reflections about the answers.

The padlet was a very useful supplement to facilitate the building of relation and confidence in the group, but did not reduce the time spend in class in creating a safe learning environment. However, it opened another important discussion about clinical uncertainty that was central to the students and that could continue through the next lessons. I would probably have underestimated the need for this discussion if I had not made the padlet. Moreover, the padlet added to setting a frame for the teaching. The questions themselves demonstrated that clinical concerns were most welcome during class and would be taken seriously. The padlet also provided an opportunity for me to reflect upon the needs of the students. Successfulness of clinical work is much about relational work. The padlet underlined

the importance about being curious about the understandings, worries and expectations of students as well as patients.

Colleague feedback to this development project at UP

My colleague supervisor, Professor Lars Bjerrum, who attended the first session where I shortly went through the answers from the padlet, suggested me to spend some more time on a dialogue with the students about their reflections on the answers to the padlet. I agree that it could give more information about the answers and give the non-responders a better chance to speak up. My colleague Gritt Overbeck, who teaches in my department and who also attends this UP course, has discussed the project with we throughout the course. Gritt's comments and ideas have been a great help to my reflections. Gritt has also read and commented on this paper, which has been very helpful to sharpen the discussion.

References

Horst, S., & Ingerslev, G. H. (2015). Teaching environment. In L. Rienecker, P. Jørgensen, J. Dolin, & G. Ingerslev (Eds.), *University teaching and learning* (1st ed., pp. 105–113). Samfundslitteratur.

Hsiang-Te Tsuei, S., Lee, D., Ho, C., Regehr, G., & Nimmon, L. (2019). Exploring the construct of psychological safety in medical education. *Academic Medicine*, *94*(11S), S28–S35.

Johannsen, B. F., Ulriksen, L., & Holmegaard, H. T. (2015). Who are the students? In L. Rienecker, P. Jørgensen, J. Dolin, & G. Ingerslev (Eds.), *University teaching and learning* (1st ed., pp. 115–133). Samfundslitteratur.

A - Patient centered communication model used in the 'Family Medicine' course

Sections	Steps
Patient	Cause of contact
	Agenda setting
	The patient's story Understandings Worries Expectations
Doctor	Diagnostic information
	Clinical examination
	Evt. paraclinical tests
	Conclusion / diagnosis
Common	Possible actions Consequences Deal

Adapted and translated by Mads Toft Kristensen

B - Answers to the padlet

Point of departure

Konsultationstræning hold 18, Region Sjælland-sporet
MADSKRISTENSEN1 27. MAR 2022, 10.32

1. Hvilke erfaringer har du med at kommunikere med patienter?

Arbejde som lægevikar
Jeg har i mit arbejde som lægevikar på hospital haft mulighed for at kommunikere med mange forskellige patientgrupper. Det gælder alle aldre samt fra alle sociale lag. Jeg står i mange tænkelige i situationer hvor patienter hjemsendes uden en diagnose, til svære samtaler med pårørende om deres familiemedlems død og nemme udskrivelsessamtaler.

Jeg har arbejdet i almen praksis i 1,5 år her sidst på studiet. Jeg har haft mine egne patienter til kontrol af hypertension og diabetes, børnevaccinationer, hjælpe med udfyldelse af svangrejournaler og andet klinisk arbejde. Derudover har jeg siddet ved telefonen og snakket med patienter.

Jeg har haft adskillige vagter på sygehuset samt som sekretær på en ØNH klinik og praksis.

Jeg har arbejdet sammenlagt et par år i to forskellige praksisser samt taget blodprøver på indlagte patienter et par år.

2. Hvad kan være svært i kommunikation med patienter?

At give dem svar
1) Det er ikke altid muligt for mig at give patienterne konkrete svar på det, de spørger om. Det kan være fordi jeg simpelthen ikke har den konkrete viden, eller at der ikke er et direkte svar. Det er kan gøre samtalen svær da både jeg og patienter ønsker at kunne komme frem til et svar.
2) Patienter, der kommer fra helt andre sociale lag eller med en helt anden baggrund end mig selv, kan være svære at nå ind til. Der kræver det ekstra af mig, at finde ud af, hvad der egentlig plager dem, og hvor godt de har forståët beskeden, jeg giver dem.

At være sikker på at de har forstået, hvad man har fortalt dem. Det er også meget svært hvis nogle er meget sure eller utilfredse, at finde frem til en fælles plan eller forståelse for hinanden.

Det største problem er min viden om den/de sygdomme, som de kan fejle. Hvis jeg ikke har godt styr på sygdommene, kan samtalen være svær. Ellers er det typisk ikke svært at få den kommunikeret til patienten.

God kommunikation er individuel. Omstilling ved hver enkelt patient for at give dem en god oplevelse kan være svær samt sammenspillet imellem rette faglige indhold og god formuleringer under konsultation. At vedholde fokus på at kommunikation er mindst lige så vigtigt som faglige.

3. Hvilke forventninger har du til de kliniske dage i en almen lægeklinik?

Overblik
- Overblik over arbejdsgangen i praksis.
- Fremgangsmåden for den almen medicinske samtale med patienten, så det hele nås på 15 min.

At få lov at arbejde selvstændigt med patienterne og lægge planer for deres forløb.
Blive god til struktur ifht at nå det man skal nå i læbet af ret kort tid.

Mine forventninger er at få et indblik i specialet og have mange samtaler med patienter.

At snuse mere til specialet og særligt fra lægesiden. Jeg er skræmt af den travlhed det fore□ndes i mange praksisser, så jeg håber at opleve overskud og god struktur til patienterne. Samtidig også et lille indblik i almen praksis mange roller - foruden at være læge skal man også køre virksomhed og ansættelser.

4. Hvilke forventninger har du til holdundervisningen, hvor bl.a. jeres patientvideoer indgår?

Gennemgang
- Gennemgang af pensum så det er til at forstå og håndgribeligt - også så det giver mening i den travle hverdag ude i virkeligheden.
- At se sig selv på video er grænseoverskridende. Jeg håber det er muligt at se udover det, og opdage gode og mindre gode sider af sin egen kommunikationsproces.

Gennemgang af de teoretiske/kliniske ting vi kan komme op i til eksamen og blive forberedt på, hvad der kan blive spurgt om ifht videoen.

Få en forståelse for det organisatoriske og måske hvordan man kan løse nogle af de udfordringer der er i almen praksis i fremtiden

At få feedback om de mangler, der skulle være samt at vise os den indstilling, som vi skal have til eksamen.
Stille os spørgsmål ligesom til eksamen.
Forberedelse til eksamen og et indblik i de vigtigste problemstillinger i almen praksis.

5. Hvad glæder du dig til eller bekymrer dig for ift. 1. De kliniske dage? 2. Holdundervisningen?

1. (Klinikken) Frygten for ikke at vide, hvad man skal stille op med patienten eller ikke vide, hvordan den konkrete patient skal håndteres.
Det bliver godt at "komme ud i virkeligheden" og få mulighed for at sidde med pt'erne 1:1 og mærke sine styrker og svagheder.
2. (Holdundervisning) Jeg er bekymret for at se mig selv på video. Det er aldrig specielt rart.

Jeg synes ikke rigtig jeg er bekymret for noget. Jeg er spændt på hvordan der bliver at overholde tidsrammen i praksis.
Jeg glæder mig til at komme ud og se hvordan en anden praksis, end den jeg har været i, kan fungere og om det er noget for mig.
Ifht holdundervisning glæder jeg mig til at blive klogere og blive klædt på til KBU.

1) **Glæde**: Se om specialet er noget for mig
Bekymringer: At stå i en situation, hvor man ikke ved, hvad patienten fejler eller hvad man skal gøre med patienten.
2) **Glæde**: Eksamensøvelse + feedback.

1) glæde: at snuse til specialet
Bekymring: egentlig ikke de store bekymringer
2 glæde: feedback og eksamensforberedende
Bekymring: heller ikke de stor bekymringer