Taking time to watch

Observation and learning in family practice

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To teach medicine without understanding education is to sail an uncharted sea. To teach without observation is not to put to sea at all. (Apologies to William Osler)

Direct observation is a key method for teaching clinical skills.[1] Defined as *observing and giving feedback on clinical skills in the natural practice environment*, direct observation has been shown to have a positive effect on the attainment of consulting, counseling, physical examination, and surgical skills. It improves resident compliance with clinical practice guidelines and increases the ability of faculty to predict licensing examination outcome.[2,3] However, as it so often happens, there is a wide gap between the evidence and reality.

What is (or is not) happening

Adults learn best when they can reflect on an experience, consider steps to improve performance, then put the lessons into practice. Pilots, teachers, and even hockey players use this approach: trainees practise their skills in front of a more experienced colleague, get feedback, make improvements, then continue the cycle.

The model works differently in medicine. Let us imagine a typical training practice in North America. The resident (or medical student) meets the patient, spends time on history and examination, then leaves the room to speak with a supervisor (who is working elsewhere). The student decides on a plan, the plan is communicated to the patient, then the supervisor signs the chart. More often than not the supervisor does not see the patient or any of the interaction.

Trainee physicians are rarely observed by their teachers. Less than half of medical students recall ever being observed conducting a clinical encounter.[4] Even when faculty and residents share a clinical session, less than 5% of the total amount of time involves direct observation of resident performance.[5] Whatever observation does take place is more likely to be focused on procedural skills rather than patient-provider interviews—the clinical encounters that form the heart and soul of family medicine. Indeed, for many trainees the most intensive observation does not come until the end of training—seated in front of an examiner in a final examination.

Why are we not observing?

Oddly enough, the evidence suggests that both medical students[6] and residents[7] appreciate direct observation; some describe it as the most meaningful experience in their training. Patients understand its importance and, given appropriate warning, are generally happy to be observed.[2]

There are 2 main barriers to direct observation in health care: teacher reluctance and the lack of a departmental culture of support.[4] We present a structure for building direct observation into family practice teaching, and give a few ideas for enthusiasts to motivate their departments.

Getting involved in observation

Preparing the practice. Successful direct observation needs planning and attention to context.

Make direct observation part of the culture of the practice: This starts at the front desk, where staff can give the positive message that direct observation is "the way we do things around here."

Prime the patient: Patients need to know what to expect and be given the opportunity to give consent. A 1-page summary of the process can be given to the patient at check-in. Signs in the waiting room can also help. We believe that signed consent is sensible, especially if any video recording is to take place.

Prepare the learner: It is helpful to mention the issue of teaching by observation the first time the learner and teacher meet. It is beneficial for residents or students to know how many visits will be observed, when the feedback is coming, how information will be recorded, and what information, if any, will be sent back to the educational program.

Choose a way to record your observations: There are various methods for recording findings. While most departments of family medicine will have something for teachers to use, even a blank sheet of paper works well. Whatever the format, ensure that the learner gets a copy of your written observations.

Rearrange resident appointments: Quality direct observation cannot be squeezed into a normal hectic day. Try to provide as much time for feedback as is spent in direct patient consultation. A session could alternate 15-minute clinical appointments with 15-minute feedback sessions. Alternatively the learner could get into a rhythm by seeing, for example, 3 patients in succession before a longer feedback session.[8]

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Three ways to observe. Given that the patient and the learner are both ready, teachers need to plan how to do the observation.

Being in the room with the learner: Traditional direct observation has the observer in the room with the learner. It is cheap (ie, requires no equipment), flexible, and guarantees an uninterrupted, real-time experience of the encounter. The biggest drawback is that the patient (and sometime the trainee) might pay too much attention to the observer (especially if the observer has been the patient's family practitioner for years). It helps if the observer sits out of the patient's line of sight and resists the tendency to participate in the encounter unless asked.

Viewing outside the room: Some training sites are lucky enough to have a room with a 2-way mirror or closed-circuit camera or video. This provides the advantage of a live viewing of the encounter without the potential distraction of having the observer in the room. Audio-only recording features can still capture the essence of the interview but miss the critical nonverbal features of communication.

Using a portable video camera: A final option is the use of a portable video camera to record the consultation for subsequent playback. This works particularly well in a setting where the supervisor is also busy or where the learner is at another site. Videotaping can generate a reasonable degree of anticipatory anxiety; however, this can be reduced by careful, positive feedback, especially following early encounters.[9]

Having tried all 3 options, we have found that in-room observation followed by a video replay of critical parts of the consultation combines rich information and targeted feedback. Being able to replay the encounter to the trainee is a powerful teaching tool.

Key elements. There is no end of complexity to the clinical encounter. Even experienced clinicians can be overwhelmed when starting out with direct observation. The following are several ideas that might help.

Focus and concentrate: Direct observation requires focus and concentration. It really works when teachers are able to devote themselves to observation for at least an hour, uninterrupted by e-mail, paperwork, or those ever present prescription requests.

Teach within a framework: Teaching within a framework for the consultation helps teachers to organize key messages. Canadian graduates might be most familiar with Stewart and colleagues' patient-centred clinical method,[10] as it is the basis of the oral component of the College of Family Physicians of Canada's Certification Examination in Family Medicine, simulated office orals. Other models include the Calgary-Cambridge approach[8] and Neighbour's 5-checkpoint model.[11]

Be learner-centred: Ask students what they would like to focus on before beginning the session. The closer the teaching matches their needs, the more likely it is to be effective.

TEACHING TIPS

- Prepare the practice by giving reception staff clear guidance and allowing enough time for uninterrupted feedback.
- Inform the learner about the expectations and feedback plans.
- Prepare the patient and give him or her a chance to consent.
- Block appointments to enable feedback.
- Choose an observation method.
- Find a method of recording the observation.
- Choose a framework for organizing observation and feedback.

CONSEILS AUX ENSEIGNANTS

- Préparez la pratique en donnant au personnel de la réception des instructions claires et en accordant assez de temps pour une rétroaction sans interruptions.
- Informez l'apprenant des attentes et des plans de rétroaction.
- Préparez les patients et donnez-leur la possibilité de consentir à l'observation.
- Organisez les rendez-vous de manière à pouvoir donner la rétroaction.
- Choisissez une méthode d'observation.
- Trouvez une méthode pour consigner les observations.
- Choisissez un cadre pour structurer l'observation et la rétroaction.

Teach process before content: While it is tempting to orientate sessions around therapeutic tips and medical facts and figures, direct observation is best suited to teaching process rather than content. Hence we try to focus on patient-centred skills, techniques for opening and closing the consultation, and ways of dealing with challenging situations (eg, angry patients, complex patients with multiple issues, telling patients bad news).

Mutual trust: The benefits of direct observation increase over time. Teachers who are new to it often think they need to present instant, incisive clinical advice. In early sessions, learners might feel as though all their real and imagined deficiencies are on display. However, just as with the patient-doctor relationship, effective direct observation depends on trust between 2 individuals. Trust, like a relationship, takes time. If you are serious about direct observation, do not be surprised if the benefits increase as teacher and learner gradually get to know and trust each other.

Giving feedback. Doing the observation is only half the battle. Our own approach to feedback begins with asking learners to give their own impressions of the encounters before presenting clear simple reflections. We try to reinforce positive behaviour and discuss options for parts of the consultation that are not working well. As the session continues, we invite learners to experiment with new approaches to subsequent

observed encounters. Finally, remember that written feedback can be a powerful tool. (Numerous examples of evaluation forms are available on-line. You can find an example at **www.familymed.ubc.ca/__shared/assets/OFFICEVISITEVALUATIONform7240.doc**.)

Role of the department

Departments have a key role in creating a culture that values direct observation. At the very least, teaching practices need to be given tools for documenting and evaluating encounters. Successful departments and residency programs have created core groups of faculty to provide professional development support for clinical and evaluation skills.[12]

Conclusion

Given sufficient preparation, focus, and time for reflection, direct observation is the best teaching tool we possess. Although it demands organization and commitment, it can be as meaningful for the teacher as for the learner. The core of great direct observation allows teaching to move away from familiar, comfortable routines to a dimension that depends on and reinforces the relationship between the teacher and the learner.

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Competing interests
None declared

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