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Black Ice

Seven tips for clinical supervision in the time of COVID 19
Sept conseils pour la supervision clinique à l'ère de la COVID

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Abstract

Virtual care (VC) rapidly has become the preferred care model in family medicine settings during the COVID-19 pandemic. Both residents and preceptors must rapidly adapt and develop new skills to provide and supervise virtual care. The College of Family Physicians of Canada (CFPC) created a VC supervision guide for family medicine residents and preceptors by quickly mobilizing a consensus driven approach leveraging existing CFPC educational committees, representing a broad range of teachers and residents in the country. The guide can be adapted to other settings and is provided in the hopes of being helpful to all preceptors providing VC and (virtual) supervision during the pandemic.

Résumé

Pendant la pandémie de la COVID-19, les soins virtuels (SV) sont rapidement devenus le modèle de soins préféré en médecine familiale. Tant les résidents que les précepteurs doivent promptement s'adapter et développer de nouvelles habiletés pour fournir et superviser les soins virtuels. Sans tarder, le Collège des médecins de famille du Canada (CMFC) a mobilisé les comités éducatifs existants du CMFC, représentant un large éventail d'enseignants et de résidents du pays, pour créer, par le biais d'une approche consensuelle, un guide de la supervision des soins virtuels à l'intention des résidents et des superviseurs en médecine familiale. Le guide peut être adapté à d'autres contextes et il est offert dans l'espoir qu'il sera utile à tous les superviseurs qui prodiguent et supervisent des soins virtuels pendant la pandémie.

Introduction

Times of ongoing crisis often stimulate lasting change and innovation.[1] In the case of the COVID-19 pandemic, virtual care (VC) has been rapidly adopted as the predominant model of health care delivery in many areas of medicine. Both residents and preceptors must rapidly adapt as well as develop new skills both to provide virtual patient care and to develop skills for virtual supervision. Providing guidance for both (virtual patient care and supervision) is the "Black Ice" problem being addressed. Post pandemic, it is likely that VC will remain a significant part of routine clinical care, thus the practices of best patient care, supervision and feedback developed for VC now will also be helpful in the future.

How it was done

The College of Family Physicians of Canada has long used a "Key Features"[2] approach as a foundation for the assessment for certification in family medicine. Key Features (KFs) were historically described in 1984 based on the insight that the resolution of a clinical problem is highly contingent on the successful manipulation of a few key elements in it. Assessment is improved by focusing only on those unique challenges in each case, the case's KFs (aspects of care that are either critical to do, often missed or done poorly)[3].

Over the course of 14 days, through deliberate use of existing structures within the CFPC, two groups, one with a mandate to provide family medicine teachers with

educational resources and the other focussed on resident assessment and certification, drafted a set of principles for virtual care supervision, including a set of KFs that can form the basis for best virtual patient care and assessment. Using this familiar KF approach facilitated the articulation of the critical elements of VC patient encounter. Given the stress of health care provision during the pandemic[4], and wanting to minimize further stress, we sought to create a tool that would use existing supervision practices within this new VC context.

What follows is the VC supervision guide[5] which has been distributed by email to all Canadian Family Medicine programs, 6,000+ Family Medicine teachers, and to resident leaders who distributed it to all family medicine residents through the CFPC's Section of Residents social media platforms. It was also featured on the CFPC website and added to the Faculty Development repository. Four virtual peer discussions were attended by teachers, educational leaders, residents and students. Other programs should be able to adapt these to their local context.

Seven tips for supervising learners providing virtual care

For the purposes of this document "virtual care" is defined as "any interaction between patients and their healthcare providers occurring remotely, using any forms of communication or information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care."[6] Virtual care includes telephone, video visits, email, and texting with newer approaches being developed and used by the medical community. Supervision of VC may also be in-person or virtual.

1. **Ask about the learner's experience and understanding of the conditions and limitations of virtual care:**

Know the VC platforms that meet privacy regulations in your province and review privacy, consent and VC limitations with learners. Currently, VC, be it by phone, video, text, email, may not fully comply with provincial privacy legislation. During the first wave of the pandemic some regulations have been relaxed but will likely tighten back up as VC becomes more mainstream (Canadian Medical Protective Association (CMPA)"Medical-legal issues and the COVID-19 pandemic – What you need to know" Webinar https://cmpa.ca/covid-19/cmpa-covid-19-updates/, open to members only). Learners knowing about regulations and striving to adhere to them as soon as feasible is important. An example of a list of secure platforms can be found on Ontario MD under the Virtual Care→Tools tab.[7] Learners must be advised that VC should not compromise appropriate care and that they need to have a flexible mindset to determine if a visit should either progress from a phone to video visit or a VC visit to an in-person visit to support that best care.

2. **Determine the Level of Supervision Needed:**

For novice learners at the stage of building foundational skills the barriers of virtual care (e.g. absent, fewer or distorted visual cues) may require more attentive prolonged direct supervision than is needed with direct patient care. Even experienced residents with strong clinical skills may require extra supervision given the unique skills required for good virtual care and a lack of experience with this type of care.

3. **Consider the Supervision Approach:**

Consistent with patient care, the supervision of trainees is also likely to become "virtual," either due to self-isolation, restrictions in travel or due to distributed models of education. For direct observation/direct listening options include speaker phones if in the same location, or 3-way conference call/videocall formats, and/or recording (with patient consent) for review if providing remote supervision. Decide how case reviews will be conducted with the learner ie. after each patient and/or at the end of a session, either in person, by phone or by videoconference with the option to text to set up impromptu discussions as needed.

4. **Ensure the learner obtains patient consent to provide virtual care:**

Medical regulatory authorities expect that patients provide consent to virtual care after their confidentiality rights are shared and they are informed of the potential limitations of virtual care. Provide learners with verbal scripts and templates for use in charting to use with patients. An example can be found on the CMPA website. Patients should be informed that information provided including photos, videos or other patient data will be shared either synchronously (with direct observation) or asynchronously (post interaction) with a supervising physician.

5. **Review the patient presentation paying attention to key features in virtual visits:**

Many VC skills are the same as with direct patient care, however VC includes some unique aspects that supervisors should watch for. Key Features are useful to focus on. They are also a useful learning resource for preceptors building their own skills in VC. See Table 1 for a list of VC Key Features.

6. **Review the learner's documentation of the virtual care visit:**

Ensure consent and pertinent information, particularly that which deviates from usual care, is included to describe the clinical encounter, the diagnosis and management plan. Co-sign the note.

7. **Provide formative documentation to assess the learner:**

The COVID-19 pandemic has significantly altered residency programs' abilities to offer the learning experiences required of learners. Providing written assessment documentation to include in a learner's portfolio will assist program directors and learners to track progress made and identify learning experiences further needed for successful completion of training. Many of the VC skills are adaptations of that you are already used to assessing. Table 1 gives ideas of language to use during feedback and assessment to optimize safe patient care and residents' growth in their provisions of VC. Document the feedback using your existing tools.

What was learned

The COVID pandemic necessitated an abrupt transition to virtual patient care and, at times, virtual resident supervision. Given the unique aspects of VC and its novelty for many preceptors and residents, quickly preparing an instructional guide for best VC and supervision was important. Using existing expertise (two educational groups within the CFPC) and tested practices (the Key Feature approach to assessment) nimble creation of such a guide was possible.

Equally important was considering how a new approach would be optimally taken up by learners and supervisors who were stretched due to the impact of providing patient care during stressful times. Layering a new approach onto an existing one and having the tool be of benefit in a number of ways (in this case, not just for resident assessment but to help both preceptors and residents build critical new skills) should hopefully increase the uptake of such endeavours.

Table 1. Virtual care "Key Features."[5]

Virtual care aspects	Key features for the purposes of formative assessment
Safe, effective use of technology and local regulations	1. *uses virtual care platform skillfully* (i.e. is sufficiently familiar with the technology used) and assists patient with using platform if need be 2. uses virtual care/telemedicine in *alignment with local regulations* especially around prescribing 3. carries out brief, relevant *consent discussion* with the patient discussing confidentiality, limitations and consent for recording if needed 4. clarifies with patient if others are present when conducting an interview to *assure appropriate confidentiality* for the patient 5. *creatively seeks and uses all available data*, e.g. asks patients to send logs, photos; if using video attends to patient demeanor, patient's background environment, asks patient to perform vitals as able (+/- with coaching), asks to show relevant areas amenable to external examination (e.g. skin, MSK, throat etc)
Adaptive communication	1. establishes rapport quickly; introduces themselves by name and role, identifies who is supervising them and how. With video platforms maintains eye contact, is aware of background distraction 2. *listens attentively* to verbal cues (especially for telephone consultation) and seeks to clarify ambiguous statements 3. documents including consent and the *rationale for deviation from typical management* and/or *follow up plans*, weighing the holistic risk to this patient
Adaptive Clinical Reasoning	1. *assesses if VC is appropriate* for this visit and recognizes when patient safety or the determination of a proper diagnosis requires an in-person assessment 2. especially with audio only, *asks probing triaging questions* to gauge severity of symptoms 3. adapts the encounter to an *alternate communication method* (audio only, video, in person) in order to facilitate safe and effective care 4. attends to the *multiple biases* that may affect clinical reasoning especially during a pandemic crisis (e.g. attributing all coughs to COVID without considering another cause)
Situational awareness	1. *adapts usual management* and follow up plans to current context 2. plans future care while *considering modified clinical operations*, and local holistic risk to the patient

These are helpful for both preceptors and learners to review to build skills for optimal virtual care, to provide the preceptor with teaching points and act as a foundation for formative assessment for learners doing virtual care.

Limitations

This guide was crowd-sourced among primary care experts for a specific context (supervision of learners doing virtual care during a pandemic) so may not represent all possible needs or requirements in all health care settings. It has not been evaluated for user satisfaction or impact on change in clinical practice or supervision.

Next steps

As VC evolves phenomenological studies will be helpful to understand the impact of VC on learners, supervisors, teaching environments and patients. Building those insights into a more fulsome guide for VC provision and learner supervision will increase the utility of this guide.

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