A Model for an Educational Virtual Ward Round

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Abstract

Background COVID-19 led to global disruption of both healthcare delivery and undergraduate medical education with suspension of clinical placements in alignment with government and university guidelines. To facilitate ongoing palliative care education, we aimed to develop a model for delivering virtual palliative care teaching and to assess the suitability of this as an alternative to in-person teaching.

Method Basic technology (iPad and linked computer) were used to facilitate video conferencing, via the secure platform Microsoft Teams, between a consultant-led ward round in a specialist palliative care unit and fourth year medical students located in the education department of the unit. This was evaluated using electronic survey responses from patients, medical students and medical staff with generation of quantitative and qualitative data.

Results Medical students greatly appreciated the opportunity to maintain attendance at clinical sessions during COVID-19. Quantitative and qualitative feedback demonstrated that the virtual ward round model effectively met medical students' educational needs, particularly in relation to holistic assessment, pain management and communication skills. Only minor technological difficulties were noted. Feedback indicated that the use of technology to allow medical education was acceptable to patients, who were open and willing to adapt. Patients acknowledged that without medical students' physical presence on ward rounds, there was an element of discretion; clinicians also found this to be beneficial.

Conclusion COVID-19 has forced changes in the delivery of medical education. Virtual ward rounds are an effective method for delivering high quality palliative care teaching and are acceptable to patients, medical students and clinicians alike. Additional benefits beyond COVID-19 included allowing students to be present discretely during sensitive conversations whilst still meeting their learning outcomes.

Article Summary

Strengths and limitations of this study

- Medical education, both during and beyond the COVID-19 pandemic, is likely to include online methods – this study shows an easily reproducible, simple method of delivering virtual ward rounds in a palliative care setting.
- This is the first study to evaluate student, clinician and patient perspectives on the utility and challenges associated with virtual ward rounds.
- To ensure patient confidentiality, this model currently still requires students to attend a setting in which streaming can be monitored: In our unit, this was within the education department.
- Number of participants were low, reflecting the rapid development of this model.

Introduction

The COVID-19 pandemic has disrupted normal ways of working across multiple sectors since it was declared on 11th March 2020.¹ The field of medical education is no exception, with many students unable to participate in traditional teaching methods, such as attending clinical attachments, as a result of the increased demand on healthcare service providers, as well as the rules surrounding student self-isolation, travel restrictions and hospital infection control policies.^{2 3}

The General Medical Council (GMC) partnered with medical schools and third parties to ensure that medical students could progress in their studies safely, recognising 'that the graduation of new doctors each year is of vital importance'.⁴ However, their statement did acknowledge that teaching methods would most likely require adjustment to ensure a dynamic response to fluctuating circumstances both locally and nationally.

Prior to the COVID-19 pandemic, medical students had expressed a desire for the rethinking of traditional teaching methods. Students felt that a blended approach, combining online and face-to-face teaching, would better meet their expectations and needs in three areas: 'connectivity, flexibility and interactivity'.^{5 6} Furthermore, in a recent meta-analysis, online learning has been shown to be superior to offline learning in its ability to enhance undergraduates' knowledge and skills.⁷ Additionally, in a separate study, it is as least as effective as offline learning in developing communication skills.⁸ Online learning should therefore be given consideration and integrated in modern medical education. In many respects, the pandemic has hastened this process.

A rapid review of forty-nine papers recently highlighted key developments in the adaptation of traditional teaching methods to a virtual approach. However, only four of these papers described a means by which to continue clinical contact in a virtual form, three of which were supervised telephone or video consultations.⁹ There is limited data available on the use of virtual ward rounds, although one very recent study involved the use of teleconferencing to allow students to witness consultations and interact with COVID-19 patients through a similar medium; an iPad on wheels. The medical students all highly valued this experience; however, there was no comment on the patients' experience.¹⁰

In our Specialist Palliative Care Inpatient Unit, we previously welcomed fourth year medical students for an educational ward round during their medical attachments. However, like all other aspects of working life, this required adaptation during the COVID-19 pandemic to minimise student, staff and patient exposure. This paper describes the model we developed to deliver a teaching ward round virtually to medical students and reviews their experience, together with that of the patients, to this novel approach.

Method

Participants

Students

Over a period of three months, fourth year medical students attended the consultant-led virtual palliative care ward round during their general medical placement. On average, three students attended each monthly session; this is comparable to the number who would previously have attended face-to-face. To ensure confidentiality, whilst complying with COVID-19 guidance, medical students attended our education suite, in a non clinical area of the unit, in person. All medical students were provided with both written guidance and verbal information prior to the teaching session: This included guidelines on the procedures in place to comply with government coronavirus advice, confidentiality, the content of the session and behavioural standard expected during the virtual ward round (appendix 1). In keeping with previous standard practice for healthcare students attending the hospice, our chaplain was able to offer support, if needed; to students should any personal issues arise from the content of the ward round. This was offered one to one in the form of online or telephone support, whereas previously this would have been in person.

Patients

The patients on the ward also received an information sheet on the day prior to the virtual ward round (appendix 2). This explained the rationale for the virtual teaching session, the technology involved in delivering the session, the expectations on the medical students in attendance and their own autonomy in deciding whether or not they wished to take part. It also addressed any misconceptions that we felt the patients may have, for example, that the session may be recorded. A member of medical staff was available to offer any required clarification on the written information to the patient and relatives. If the patient did not have capacity to consent to the above, we sought permission from their next of kin present with them.

Procedure / model

Medical students attended the education suite within a non-clinical area of the specialist palliative care unit in person; they were, socially distanced in a large room where they observed the ward round on a projector screen. This projector was connected to an NHS desktop computer with a webcam and microphone to allow two-way communication. A member of the clinical team logged in to this computer using their secure clinical accounts.

Using Microsoft Teams as a secure platform, the session commenced with our daily morning handover, allowing the medical students the opportunity to interact with the wider multi-disciplinary team. Following this, the medical team, utilising an iPad for the duration of the ward round, connected solely with the medical students via Microsoft Teams. As previously described, this enabled two-way communication with the clinical team and allowed the students to engage with the ward round in its entirety. Published data indicate that iPads can be safely sanitised with readily available cleaning equipment between use^{11,12} providing added reassurance regarding infection control procedures.

In keeping with standard procedure for face to face teaching ward rounds, the clinical team provided a short background summary of each patient to the students discussing relevant points and offering an opportunity to ask questions. The patient's (or relative's) consent was then sought again prior to entering the room. To minimise patient and staff contact, only one junior doctor, carrying the iPad, entered the patients' rooms alongside the consultant. Other members of the clinical team joined the call from a separate desktop computer in the doctor's room and documented the ward round; as has become standard practice in our specialist palliative care unit to minimise contact whilst maintaining safety of contemporaneous record keeping during the coronavirus pandemic. Thus a minimum of two healthcare professionals (consultant and one other) were required to complete the virtual educational ward round (figure 1). Following the consultation, the iPad was cleaned with clinical wipes, before the consultant led a discussion on the patient's symptoms and the potential management plans.

Analysis

Following the virtual ward rounds, we collected both quantitative and qualitative data anonymously from each medical student, as well as from those patients where appropriate (in terms of capacity and fatigue) via electronic questionnaires. Both students and patients were asked to provide responses to a set of tailored questions utilising Likert Scales. However, they were also given the opportunity to expand on their answers in free-hand text boxes. From these free-text answers SPB and PJD undertook thematic analysis to produce the results below. The feedback was collected electronically and saved in a password protected, encrypted device.

Ethical Considerations

We sought the guidance of our local Caldicott team in relation to the evaluation of the patient and student feedback from the virtual ward rounds. It was deemed that formal Caldicott approval was not required for this: Instead, verbal consent was obtained from patients and medical students to participate in the ward round but also to provide feedback and for this to potentially be used in a publishable format. In cases where patients were unable to consent due to delirium or conscious level, consent was obtained from next of kin for participation and these patients were not included in giving feedback. If it was deemed that due to patient distress participation was not beneficial, then these patients were also excluded.

An organisational position was agreed in relation to digital information governance that facilitated the use of virtual media for continuation of critical clinical care; this was extended to include provision of medical education.

Results

Student Feedback

Between August and December 2020, four educational virtual ward rounds took place. Twelve medical students in total attended these ward rounds, with each student completing the feedback form and all feedback included in the analysis. This was the first virtual ward round that any of the students had attended. Students on the whole considered this to have been a positive experience with all answering 'agree' (6/12, 50%) or 'strongly agree' (6/12, 50%) to, 'The virtual ward round has helped to prepare me for caring for people who are dying and their families'. Students felt they gained knowledge and skills in multiple domains of palliative care through attending the ward round remotely with results detailed in Table 1. Encouragingly, there were no negative answers to any of the questions exploring confidence on preparation in caring for the dying, understanding of holistic care, confidence in structured pain assessment and insight into complex communication skills with the majority of answers being 'agree' or 'strongly agree'. All students felt that the virtual ward round offered a suitable alternative to bedside teaching – 9/12 (75%) opting for 'strongly agree' and 3/12 (25%) 'agree'.

Table 1
Student feedback following the virtual ward round.

Question	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
The virtual ward round has helped to prepare me for caring for people who are dying and their families	9/12 (75%)	3/12 (25%)	0	0	0
The virtual ward round has helped to improve my understanding of patient centred holistic care	9/12 (75%)	3/12 (25%)	0	0	0
The virtual ward round has increased my confidence in carrying out a structured pain assessment	2/12 (16.67%)	8/12 (66.67%)	2/12 (16.67%)	0	0
The virtual ward round offered me insight into the complex communication skills required in caring for patients and families at the end of life	9/12 (75%)	2/12 (16.67%)	1/12 (8.33%)	0	0

The free text feedback came from questions relating to any other comments or feedback. This has been extrapolated into the following themes:

Opportunity to Participate in Ward Rounds

Students appeared able to acknowledge that the circumstances of the pandemic preclude physical attendance on ward rounds, although they feel that this would have been the preferred method: *'I think it is always better to be there in person, but it is completely understandable why this is not currently possible'*. They did however still feel the virtual ward round offered a valuable opportunity to actively participate in ward rounds: *'allowed us to experience something we might otherwise not'* and was

acceptable given the current working conditions during the pandemic: *‘excellent way to see the patients without being too close’* and *‘able to watch conversations I would have otherwise been unable to’*.

Students appreciated the opportunity to see candid, uninhibited interactions between staff, patients and families: *‘I felt really privileged to watch really difficult conversations with patients and their relatives’*.

Structure of Ward Round

Overall, students were positive about the effectiveness of the structure of the virtual ward round. They found that the background information on patients prior to their review was important and they appreciated being involved in planning and management discussions thereafter: *‘I liked the structure of the teaching – we were given background info on the patient, then watched the patient/doctor interaction and then had another chat about the plan going forward’*. They found that having this background information improved their knowledge: *‘it helped improve our understanding in managing the patients’*. Engagement before, during and after patient consultations was appreciated as a way of ensuring students felt included in the ward round activity and that their learning needs were addressed: *‘meant we had the “attention” on the ward round as sometimes in person you can get lost in the huddle and feel a little left out’* and *‘making sure we were comfortable and knew were [sic] understanding everything that’s going on’*.

Knowledge

For this cohort of students, this was the first time in their undergraduate careers that they had participated in a palliative care ward round. Feedback suggests that despite the ward round being virtual, students still gained meaningful knowledge and experience in palliative care. This is highlighted in the collection of quotes below:

- *‘Holistic care is key for palliative care patients’*
- *‘...it’s not all around managing someone immediately prior to death. It is also about managing symptoms including pain and how best to manage a patients’ goals and desire for care.’*
- *‘It’s important not to shy away from talking to patients about palliative care’*
- *‘very patient centered [sic]’*
- *‘Look at the big picture and what is in the best interest of the patient and their care’*

This helps meet desired competencies as outlined by the General Medical Council in their Outcomes for Graduates⁶.

Technology

There were occasional issues with technology, particularly in relation to WiFi coverage in some of the patient rooms in which the connection intermittently failed. Students appeared accepting of this and overall, felt it did not significantly impact their learning experience adversely: *‘Unfortunately technology was not on our side, but we managed in the end’*. Helpful suggestions were given, should this happen again, such as providing the students with written information on each patient in advance: These will be

considered and implemented, with measures to protect patient confidentiality, for the next cohort: *'...the connection would go off sometimes and then we wouldn't be too sure of what had happened to the patient or what was going on with them. So some sort of background on the patients would be good'*.

Patient Feedback

In total, between the four virtual ward rounds, a total of nineteen patients were present on the ward. Consent was gained from eighteen of the patients or their next of kin with one patient declining to have medical students present. Of the eighteen patients that took part in the virtual ward round, eight of the patients were able to answer our feedback questionnaire.

All of the patients (8/8, 100%) stated that they had received an information leaflet prior to the virtual ward round. The majority had previously encountered medical students on a hospital ward during a previous admission (7/8, 87.5%). None of the patients (0/8) reported feeling that having medical students present virtually impacted on the quality of the care they received, and all reported they would be willing for medical students to join the ward round more often in this virtual manner (8/8, 100%).

Acceptability

Free text responses suggested that patients found the use of technology acceptable to enable the medical student's attendance on the ward round. This was due in part to the previous experiences of some patients. One patient described her previous work as a factor in her decision to allow students to be present: *'I was used to teaching students in my previous work so was happy to have them'*. Another likened this to other jobs having apprentices: *'...the best way to learn is to follow the doctor like any tradesmen would'*. These comments are in keeping with those frequently made when students are present on the ward and an understanding of the medical teaching ethos.

Adaptability

Patients acknowledged that the current pandemic has an impact on students learning experiences and appeared to be adaptable in assisting to mitigate this: *'it's important that they have a chance to learn and if that's how it has to be these days then that's what we have to do'*. Another acknowledged that their own familiarity with technology had improved as a result of their experiences in the pandemic and this made the virtual ward round more acceptable: *'I have used 'zoom' with my family for conversations and quizzes and had virtual outpatient clinics. I feel more comfortable with it now than I would have a few months ago'*.

Discretion

It was noted that the virtual ward round allowed students to be present more discretely, with patients feeling they *'hardly noticed them'*. *'I wouldn't have known they were there if I hadn't been told as it's a bit different not having them all following the consultant about'*. One patient acknowledged that the discretion of virtual attendance offered benefits to students as well as to patients: *'It felt more like a one-*

to-one. They were more able to listen to the conversation between me and the doctor rather than being distracted by each other or what else is going on.'

Clinician Feedback

The impact of discrete student attendance was also noted by those clinicians carrying out the virtual ward round. On a number of occasions, without hesitation on the patients part, complex consultations such as; diagnosis, disease progression or resuscitation, took place organically, candidly and with open expression of emotion. Uninhibited dialogue, between the patient and the doctor is not always possible when a number of medical students are physically present in the room. Although daunting at first, we have gained confidence in the use of Microsoft Teams for the purpose of a virtual ward round, in part due to the success of its implementation in other areas of local service, such as multi-disciplinary meetings.

As we became more familiar with the technology, the time taken to prepare for and support a virtual ward round reduced and became negligible. As noted, there were minor problems on occasion relating to the WiFi coverage in the unit, however, on the whole, the time taken to complete a virtual ward round was comparable to that of previous palliative care teaching rounds.

Discussion

Medical education has had to evolve and adapt rapidly due to the current COVID-19 pandemic. Our paper describes the evaluation of a simple model to enable students to attend ward rounds virtually: There is no prerequisite for advanced IT training and minimal specialist equipment is required. The technical aspect involves an iPad or tablet with video capability, and a computer with a webcam and microphone. Our team in this specialist palliative care unit, did have prior experience of this format having developed a model of virtual consultant-led ward rounds.¹³ Regarding the technological aspects of the ward round, only minor problems were encountered and these related to WiFi coverage; however students appeared sympathetic to this. In view of the student feedback and expectations of ongoing virtual working, we were successful in securing resource to upgrade the WiFi coverage in the unit. There have been prior studies identifying perceived barriers to implementing telemedicine in general, particularly around technically challenged staff, resistance to change, cost, reimbursement, patient age and level of education of the patient.¹⁴ Although our model had support for patients from staff who were familiar with the technology required, the process was relatively straightforward and took little in the way of time to prepare for and set up.

We have demonstrated that virtual ward rounds are feasible, acceptable and beneficial for both patients and students alike in a specialist palliative care unit. Our feedback was wholly positive in relation to all aspects of patient and student experience. Importantly, students still felt engaged in the virtual ward round, and were able to gain essential palliative care skills through this medium of teaching. It was interesting that, in addition to meeting their learning needs, the students felt more rather than less

included through their attendance virtually. Their sense of inclusion related to time taken to offer an interactive experience, including briefing prior to 'entering' the room, observing the consultation and debriefing afterwards. It is important to recognise that this would be standard practise during face to face teaching ward rounds in the specialist palliative care unit and is frequently commented on positively in many years of prior feedback. None of these students had previously attended a palliative care ward round and hence would not have had prior expectations.

The relatively basic technological skill required to carry out a virtual ward round via Microsoft Teams, is similar to that of video consultations which have become relatively commonplace in the day to day working of the NHS. In Scotland the use of 'Near Me', a video consulting service increased 50-fold between March and June 2020, from 330 per week to just under 17,000.¹⁵ Local evaluation has demonstrated that healthcare professionals using 'Near Me' to review palliative patients, found it to be a positive experience overall: Benefits included reducing staff and patient travel, enhancing efficiency of consultations and improving access for patients who may be too frail to attend distant clinics. It was acknowledged that this platform benefitted select patients with digital capability and complimented rather than replaced face-to-face reviews.¹⁶ The majority of patients who have participated in 'Near Me' clinics within our Palliative Care service, considered this "as good" or "nearly as good" as face-to-face clinics: Advantages included reduced travel time, comfort and convenience and avoiding risk of infection, especially during the COVID-19 pandemic. Only a small minority described experiencing technological difficulties.¹⁷

Therefore, in keeping with the literature, our model demonstrates that virtual ward rounds can be a useful way of allowing multidisciplinary team members to attend.¹⁸⁻²⁰ It is also a useful way of obtaining expert opinions from staff in other centres and reduces the burden of travel; particularly relevant during times of imposed travel restrictions. Furthermore, we were able to demonstrably reduce footfall through patient rooms, thus minimising potential patient, staff and student exposure to COVID-19, as well as conserving personal protective equipment (PPE). We anticipate that the evidence we have presented will improve the confidence of other clinical teams who may seek to engage other healthcare professionals, both qualified and in training, through virtual media.

Our evaluation offers reassurance that virtual ward rounds facilitated our patients in focussing directly on their interaction with the consultant, without the distraction of students being physically in the room, despite being aware of their presence. This may facilitate a more organic experience of the ward round during which the established doctor-patient relationship and interaction is uninhibited. This enables observation of true, non-attenuated consultation, thus enhancing both patient and learner experience. An increasing body of evidence indicates the high value that palliative patients place on their inclusion in research, learning and teaching for potential personal benefits as well as altruistic goals of benefiting others.²¹ Similarly, we have demonstrated that our groups of patients found the format of the virtual ward round to be acceptable and they relished the opportunity to be involved in educating the next generation of healthcare professionals.

Strengths

This model demonstrates delivery of ward rounds involving medical students in a format that is acceptable and effective for students and patients alike. This responds to previous studies wherein medical students have called for modernisation and modification of traditional teaching methods. This is the first study to our knowledge that includes patients' feedback regarding the use of technology to deliver ward rounds to students. Our model had on average three medical students attending each session; however, with progression in vaccines and increased knowledge of COVID-19, in future there may be scope for larger numbers to attend.

Limitations

Students did still have to physically attend the education suite in our unit due to our imposed strict confidentiality criteria, therefore this model is limited in terms of delivering education to those isolating or during times of restricted travel. This model does require basic technology: iPad or tablet and computer with camera and microphone as well as reasonable WiFi connection. However, we are aware that there has been significant investment across the NHS in this technology to adapt services in direct response to the coronavirus pandemic (virtual clinics, virtual visiting etc) and that such technology should likely become available in all healthcare settings in the near future to facilitate modern healthcare provision and education.

Conclusion

In summary, we have demonstrated that virtual ward rounds can be delivered effectively and successfully to involve medical students in an interactive, engaging learning experience. The involvement of patients in our feedback has shown that their familiarity with technology has greatly increased during the pandemic and they found the use of the iPad to allow students to be present to be less intrusive than physical attendance. For specialties such as palliative care, with full prior consent, the complex, subtle interactions of an established, trusting doctor-patient relationship can perhaps be more truly observed discretely, from a far. In other settings, virtual ward rounds may offer a far larger number of students to observe clinical learning. As we emerge from this pandemic, we anticipate the continuation of blended models of medical education delivery involving the adaptation and augmentation of aspects of best practice; we consider that the virtual ward round has permanent place in the future of medical education.

Abbreviations

COVID-19: Coronavirus disease 2019

GMC: General Medical Council

NHS: National Health Service

Declarations

Ethics Approval

A discussion was had with the local Caldicott guardian and it was deemed neither Caldicott nor ethical approval was required for this study.

Consent for publication

Consent was gained from all participants (patients, medical students and medical staff) for both participation and publication of these data. All authors have revised the final version of this paper and consent to its publication.

Availability of data and material

The authors confirm that the data supporting the findings of this study are available within the article.

Competing interests

There are no competing interests

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Author contributions

All authors contributed to the study concept and design. SB and PD are joint first authors. PD liaised with the medical school in recruiting medical students to attend the virtual ward round. KT was the lead consultant delivering teaching during the consultant-led ward round. SB and PD developed the study questionnaire and obtained patient and student consent for participation. SB and PD contributed to the data acquisition, interpretation and presentation and writing of the manuscript. KT provided overall supervision of the study, had full access to the data and provided critical revision of the manuscript.

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Appendix

Appendix 1

Virtual Ward Rounds – Student Guide

4th year Palliative Medicine Teaching Roxburghe House

Welcome to Palliative Medicine teaching during your 4th year General Medicine block. We wish to give you valuable learning, including real patient experience.

Due to changes related to Coronavirus we are altering the way we deliver this teaching session. This is to recognise government guidance around social distancing and is influenced by our healthcare environment and that patients in our inpatient unit are generally a vulnerable group.

We would usually have you physically present in Roxburghe House inpatient unit and joining us on the consultant ward round as we review patients. Patient contact is essential for you learning to be doctors and we still wish to provide this.

We are able to provide this by you joining the ward round remotely using technology supporting Microsoft Teams. You will do this from within the Roxburghe House Education suite.

It is important that you read the following information and meet the requirements for joining this session.

If you have any questions, please contact – could we say Nancy?

Before session

Please do not come to Roxburghe House if you are unwell. It is essential that you do not come if you have any symptoms of Coronavirus.

On the day

Please come to Roxburghe House for 08:50 on your allocated day.

Follow directions to the Education Suite (left up the corridor, door on right and up the stairs that are on the left as you go through the door.

Please observe social distancing, hand hygiene and wear a face covering at all times. There are masks and hand sanitizer at all entrances.

You will be having patient contact so please meet the usual requirements for being in a clinical environment e.g. professional appearance and dress.

The team on the day will go over with you what to expect.

Patients and staff will know that students are joining the ward round in this way. Patients will have given consent for your involvement.

During the session

Please approach this session as if you were in the clinical area. Please act professionally, respectfully and in line with the Medical Student Charter.

Patient confidentiality must always be observed including after the session.

Please switch mobile phones and any other devices off and please put them away.

No audio or video recording is permitted.

Any breach of confidentiality or lapse in professionalism will be acted upon.

After the session

Your feedback on this way of gaining clinical experience is very valuable to us, our patients and the medical school.

Please give feedback via the online form.

You may have found aspects of the day sad or upsetting, is it normal to feel this way. A member of our Spiritual Care Team will support this session.

Appendix 2

PATIENT INFORMATION – VIRTUAL WARD ROUNDS

Due to the COVID-19 pandemic, healthcare providers are asked to keep *direct patient contact* to those most important for providing care. This is to reduce the risk of transmitting the virus. As a result, many routine aspects of healthcare have adapted to use technology to support clinical work.

At Roxburghe House, we too have been establishing new ways of working to reduce the number of people you come into direct contact with. We have developed a way of using Information Technology to allow some of our team to join ward rounds remotely from non-clinical areas (where there are no patients). This is done using a **secure platform** called Microsoft Teams which is approved by NHS Tayside for this purpose. The team members working remotely can link with the team on site securely through Microsoft Teams: One of the team in your room for the ward round will have a tablet/portable device through which you can see those working remotely and they can see and hear you on their computer.

The team members working remotely are in a private room and bound by the same rules of confidentiality. If members of our team are joining the ward round remotely and seeing you then you can expect the following:

- They will be in a private room
- They will introduce themselves
- They will behave with the same professionalism as those in the room with you
- They will fully respect your confidentiality
- The consultation will not be recorded – it is in “real time” only

Medical students are part of the healthcare team in NHS Tayside and they are recognised as Key Workers. Medical students value patient contact and this is important for them learning to be doctors. Medical students may join the ward round.

If medical students are joining us in this way:

- They are in Roxburghe House in a private non-clinical area

- They will not have mobile phones with them
- They will also follow all of the above points (introduction, professionalism, confidentiality, no recording)
- **The team on site will ask your permission for Medical Students to join the ward round remotely – you have the right to refuse and this will not affect the care you receive at all**

If you have questions about this or wish to discuss this further, please speak with the team caring for you.

Thank you.

Figures

Figure 1

Virtual Ward Round Method