

Enhancing Learning for Medical Students in Psychiatry—Ethnographic Explorations

Cecilie Fog-Petersen*

PhD student,
University of Copenhagen & Region Zealand,
Psychiatry Vest, Fælledvej 6, 4200 Slagelse, Denmark

Karen Borgnakke

MA, DHA, Professor,
University of Copenhagen,
Karen Blixens Plads 8, Building 14, 3rd floor, 2300 Copenhagen S, Denmark

Sidse Arnfred

MD, MSc, PhD, DMSc, Associate Professor,
Dep. of Clinical Medicine, Faculty of Health, University of Copenhagen &
Region Zealand Psychiatry, Psychiatry Vest Fælledvej 6, 4200 Slagelse, Denmark

Abstract. *We describe an ongoing study investigating the main learning conditions for medical students during clinical attachment in psychiatry. The focus is on how a new video library is used in practice as a supplementary learning tool. The study is based on ethnographic methods and draws on Lave and Wenger, Dreyfus and Dreyfus, and Dewey. The article provides examples of empirical studies and briefly elaborates on the challenges of the chosen methods.*

Keywords: *ethnography, video, apprenticeship, psychiatry, medical education, blended learning.*

Introduction

In psychiatry, one of the 38 medical specialties in Denmark, the traditional clinical training of medical students is challenged by a significant shortage of specialists and a political demand for higher bed turnover. This results in limited patient contact and

a lack of bedside teaching and supervision for medical students, which threatens the professionalism of future specialists (Holm-Petersen 2006; Varma 2012). Psychiatry is considered a low-prestige medical specialty, and mental illness is still highly stigmatized. At the same time, the number of patients in psychiatry is growing and the WHO expects it to keep growing (Regioner 2009). This leaves little hope for the improvement of conditions for the traditional clinical training, i.e., apprenticeship.

*** Corresponding Author:**

Cecilie Fog-Petersen, Psychiatry Vest, Research Unit,
Fælledvej 6, 4200 Slagelse, Denmark.
Email: cempf@regionsjaelland.dk,
Mobile: +45 50988940

Ideally, the clinical apprenticeship is the route to mastering the complexity of the discipline, which is hard to understand even for professionals (Chur-Hansen & Parker 2005; Parnas, Sass, & Zahavi 2013). Fieldwork and conversations with students confirm that the discipline is hard to grasp for newcomers (Fog-Petersen 2014a), and we set out to augment the clinical training by offering the trainees a video library as a learning tool.

In researching our earlier work, we have only found few academic studies concerning the use of video as a learning tool in psychiatry, although many videos on the mental state examination can be found on the internet. At the same time, there is a shortage of empiric studies concerning the daily teaching and learning practice in higher education (Borgnakke 2011).

In the present research, we therefore investigate the daily clinical psychiatric practice as a context for training and learning in a hospital setting as well as the impact of the new video library.

In the research project, we aim to understand the main learning conditions for students during clinical attachment in psychiatry and to understand how a video library is used in practice as a supplementary learning tool during apprenticeship. In that sense, the study is set both to investigate the traditional training and context for the training as well as to invest the impact of proposing an experimental new tool into the traditional context.

Inspired by Lave and Wenger (2003), we characterize the clinical training as *situated learning* embedded in the daily practice at the hospital, and we show how the medical students, as newcomers, try

to be actively involved in daily psychiatric practices. The newcomers' access to the daily practice is not easy, as illustrated in the later empirical example. Newcomers are "novices" in the field and not yet equipped to cope with psychiatric patients. Inspired by Dreyfus and Dreyfus' stage model (1986), we therefore elaborate the description of the development process from novice to expert/professionalism, and we show the consequences for the students' strategy as newcomers.

As can be seen in the following pages, the psychiatric hospital – as a setting for the medical students' attachment – is a complicated setting where the focus is on patient treatment and not on training, even though the core concepts of the field are understood to be elusive and intangible.

The investigation of the specific learning situation and hereby the "situated learning" in daily psychiatric hospital practice, as well as the exploration of the traditional course in clinical training, call for ethnographic methods, such as participant observation, spontaneous dialogues and more structured interviews. Furthermore, the practice field, the daily routine (as a mirror to the basic "tacit knowledge") and complex interaction between professionals and students demand both spontaneous dialogues and detailed descriptions of the daily practice within the situated learning to be used as a foundation for future analysis.

The investigations are ongoing, and in the present process description, we argue that a methodology combining social constructivism and ethnographic methods must support a study embedded in the setting of psychiatry and exploring the practical context of learning. The argument

opens with a description of the complexity of a psychiatric hospital as the learning context. Next, we provide a short theoretical clarification, followed by a description of the methods with examples from fieldwork, followed by a short elaboration and summary of the main points in the article. The article is written by three authors, of whom Cecilie Fog-Petersen has done the fieldwork.

Setting the Stage for Clinical Training: The Psychiatric Hospital

The study is carried out at the Psychiatric Hospital in Slagelse, run by Region Zealand, one of the five administrative regions of Denmark. In Denmark, regional psychiatric treatment is a free public service. The hospital opened in 2015 and offers psychiatric wards for inpatients and outpatients as well as a forensic and a geriatric psychiatry section. The four inpatient wards consist of a staff office, surrounded by patient rooms, an open common area for eating and a common room for activities, such as watching television and playing board games. Described as a working place and, for the medical students, as a learning context, it is important to stress that the hospital differs from a more traditional institutional hospital layout in many ways. The buildings are designed and constructed to enable transparency and mental recovery with many windows, bright and broad hallways and green garden areas. However, the welcoming hospital design does not change the characteristics of the patient group, which includes patients who are in the most demanding stages of mental illness and who can be a danger to them-

selves or others. Because of these risks, staff and students need to carry warning devices, and the exit doors from the wards are routinely locked to ensure that certain patients do not leave the ward. The treatment period of inpatients varies from a few days to months, depending on the purpose of their stay. During hospitalization, the doctors and staff at the ward are responsible for the patients. This means that the medical student need both the doctor's or staff's permission and the patient's permission to get access to the patient. Furthermore, the medical students are not allowed to be alone with the patients – they can only approach patients if some of the staff or other students have time to join them. This means that it can be difficult for the students to get access to the patients.

When patients arrive at the hospital, they are interviewed and examined, and, if needed, they are admitted to the psychiatric emergency department. After one or a few days of observation, it is decided whether the patient has recovered and can go home or needs a longer admission period in one of the four stationary wards. Each of the four wards can accommodate up to 17 patients, while the emergency department has room for 12 patients. Every morning and noon, staff representing the four wards and the Psychiatric Emergency Department meet at a conference to discuss the treatment of patients and decide the transfers to the wards. The dialogue is often about the high bed occupancies and the demand for quick patient turnover.

A doctor and a head nurse should lead each of the stationary wards as well as the psychiatric emergency department. However, due to the shortage of psychiatrists,

Table No. 1 Explanations of applied terminology.

<i>Clinical clerkship/ attachment</i>	A workplace period of the medical study where students participate in daily clinical routines. Introduced in 1893 and today an essential part of the medical curriculum across the globe.
<i>Bedside training</i>	Participation in the ward rounds with supervised duties based on competence is considered the hallmark learning process during attachment and residency.
<i>Residents</i>	Doctors in post-graduate educational employment rotation periods before becoming specialists.
<i>Doctors</i>	In this study, the term “doctors” cover both residents and psychiatrists (specialists in psychiatry).

one psychiatrist frequently covers two or more wards, and a resident oversees the ward rounds. The staff in the wards include a mix of professions, such as doctors, nurses, social workers, caretakers, psychologists, but the fieldwork shows that the medical students are mainly orientated toward doctors.

Educational Context for Medical Students

To become a resident, medical students spend six years (12 terms) at the university. The medical students involved in this study are enrolled in the medical school of the University of Copenhagen. The curriculum is primarily discipline-based, with only a few system-based courses at the preclinical bachelor level. The clinical, master-level studies consist of a mixture of brief and longer courses including both scholastic teaching – mostly lectures and student activating classes at the university – and the clinical attachment periods at different hospitals across two regions. The brief psychiatry module is a mandatory part of the 10th term of the medical educa-

tion at the University of Copenhagen. The module runs for four weeks. One week is structured as traditional academic lectures, while the rest of the period is dedicated to clinical attachment at a psychiatric hospital (see Table No. 1 for terminology). At the hospital, training is by way of apprenticeship and group instruction. The attachment is most often at a psychiatric department with inpatients. The attachment has several purposes: the students meet patients, get to know the working circumstances of the speciality, they practice taking patient histories in preparation for the medical exam and gain experience with various clinical tasks. A significant goal of the attachment in psychiatry is to learn how to conduct a mental state examination and write the clinical assessment.

For some students, the attachments in psychiatry are their first meetings with psychiatric patients. Other students have met psychiatric patients as part of their student jobs as nurse assistants, sitting by acutely mentally ill patients in mechanical restraint. The observations and spontaneous talks with the students show that both types of students could have negative

assumptions about psychiatry when they start at the attachment. At the same time, the students find the psychiatry speciality very different from other specialities and feel insecure about how to act when they start in the attachment. As a consequence, both the the assumptions for learning psychiatry as a discipline and as a professional practice are challenged.

Basically, the learning situation for medical students in clinical attachment is that learning is not formalized but integrated in the daily practice. In this sense, students learn psychiatry by participating in the daily practice, pointing to the importance of taking part in practices to be able to understand professional techniques, treatments processes, relations to patients and the social relations characteristic for the ward. The learning situation is different in case of the video library. When the new tool like the video library was introduced, it was called “in-between blended learning.” It is *in-between* because the videos are not instructions or theoretical material but are more like a frozen clinical encounter; they may, at the same time, be viewed in the wards together with colleagues and in the office in solitude. With the video library described as blended learning, the point emphasized is that the video library, as a learning tool, is a compensatory effort, meant as an aid for enhancing the students’ knowledge about psychiatric patients. The video library should also be stressed as an alternative to the textbook, since the students, while working with the videos, can see and hear patients tell their story (the living told story) and not only read it. All in all, we will describe the video in use as patient-focused blended learning (poten-

tially linked or related to the patient ward), a living textbook and an academic source suitable for further study. But the main purpose of the video library is still to be understood as a compensatory, patient-oriented learning method meant to fill the gap and meet the challenge for contact with psychiatric patients.

After ending the attachment in psychiatry, the students rotate between attachments in neurology or child and adolescent psychiatry, and, at the end of the term, they must pass a combined exam in psychiatry and neurology/neurosurgery. The psychiatric syllabus at Copenhagen University is outcome- or competence-based, and the examination is a traditional *long case*, that is, a situation that mimics a clinical encounter (75 minutes for a clinical interview), after which the student reports the findings and conclusions to the examiner, and any broader topics related to the case are discussed. In this sense, the medical students end their period of learning by participating in the clinical practice context by doing conventional assignments and exams in the scholastic context.

In the research project, the shift between the clinical practice context and the scholastic context is present both in terms of being a vivid part of the tradition of medical education and in terms of being a challenge for routines and experiments in the field.

The Video Library

The video library was developed in 2015–2016 to help students in getting “access” or observe patients with metal health problems and getting access to an elaborated

opinion of an experienced psychiatrist regarding the patient. The video library now consists of 19 videos; each video shows a different patient with mental health problems being interviewed by a doctor in psychiatry. The patients are mostly inpatients, with a few outpatients, who are participating voluntarily in the video interview. To make sure the patients were informed and agreed to be a part of the video library, they were asked to complete a signed, written consent prior to the recording, and they were asked to confirm the consent two weeks later.

During the interview, the doctor followed a short interview guide in order to quickly get a picture of the patient's present mental health symptoms and problems. The full video of each interview varied in length, but they were afterwards edited to shorter versions of 8 to 13 minutes. Each video came with two short text pieces: a very brief recapitulation of the medical history, drafted by the interviewing doctor, and a mental state examination made by a professor in psychiatry. The mental state examination describes the patient's symptoms, and a good examination requires knowledge of the psychopathological phenomena, an assessment of the current mental state and competent and empathetic communication as well as exercise in the interpretation of the patient's statements. The 19 videos and the text material can be accessed only through a secure website at the hospital; however, once access is allowed, it is easy to access from any computer at the hospital using personal, organizational login credentials.

In other medical specialities, videos

used in training situations have been very beneficial (Hammoud, Morgan, Edwards, Lyon & White 2012; Larsen 2010). Videos can isolate and identify non-verbal communication (Corradi, Wasman & Gold 1980; Gask 1998); they can help to break down the complex to more understandable pieces and they make it easier to take a closer look at signs and symptoms (Dogra 2000; Roeske 1979). In our earlier studies, we offered the use of self-made video recordings for medical students during their psychiatric attachment (Fog-Petersen 2014a; 2014b). These students described how the core concepts of psychiatry are embedded in abstract academic descriptions and they asked instead for videos demonstrating symptoms and interview situations (Fog-Petersen 2014a). Consequently, we tried three different e-learning tools from English speaking countries, testing if e-learning could be the answer to these needs. The students found the e-learning tools helpful to some degree but were troubled by the differences in terms and concepts between Danish and English. Students expressed concern about the demonstrations in the e-learning tools, whether the people depicted were real patients or actors and, they if actors, whether they were truly valid in their performances. The patients in question were actors, and this fact made it seem worthwhile to produce a video library with real patients, although this poses some constraints due to the protection of patient privacy. The video library is processed and stored in accordance with the rules of the Danish Data Security Agency (ID: REG-96-2015).

Theoretical Foundations for the Study

The field's approach to learning as apprenticeship and the experimental characteristics of the video library is a challenge for the theoretical foundation. Dewey, Lave and Wenger as well as Dreyfus and Dreyfus all provide perspectives on the practice-oriented learning processes. But the basic categories need to be further developed and related to the field's specific, profession-oriented process of training and learning in psychiatry.

To look at training in clinical practice is to basically sharpen the Deweyan optic at "someone doing something." It means looking at the professional repertoire of actions in the field as well as in the interaction and communication between doctors and patients. This Deweyan optic implies that we regard practical experience as closely connected and focused on situated actions and the reflections connected to the actions. Furthermore, it not only implies reflection before action but re-reflection and actions in new situations as well (Borgnakke 2004; 2005). Dewey's concept of learning by doing is useful for the specific understanding of how the students gain knowledge and skill; next, Lave and Wenger's concept is useful to specify the medical students' learning processes as embedded in communities of practice, social relations and activities in contexts (Lave & Wenger 2003; Wenger 2009). With these concepts, the clinical attachment is to be elaborated as an apprenticeship model, assuming that medical students will grow professional identity and knowledge when they are closely connected to the clinical environment and

the experts of the field (Lave 1999). In other words, we find Lave and Wenger's concepts and the basic category of *situated learning* useful for the description and understanding of the learning processes among medical students in psychiatry. The hospital-based medical apprenticeship form is already well-described internationally in relation to learning clinical diagnostic deduction and treatment planning (Bowen 2006; Pugsley & McCrorie 2007).

While apprenticeship is the general term, learning is frequently ascribed in medical education to bedside training (see Table No. 1) or clinical mentorship, that is, being more based on a doctor-to-doctor contact than any socialization with the entire practice of the hospital ward. As stated, organizational changes have undermined the bedside training and the possibility of situated learning, and the video library offers an alternative setting for situated learning.

With Lave and Wenger's concept of the relation between newcomers and old-timers and of *legitimate peripheral participation* (Lave & Wenger 2003), we describe how the medical students enter a community of practice as newcomers and try to become members of the psychiatric community. To be specific, in connection with the field's own characterization of the spectra of professional skills from novice to expert, as stressed previously, we find Dreyfus and Dreyfus's stage model (Dreyfus 1986) and Borgnakke's elaboration of the model (Borgnakke 2005; 2014) useful. No one claims that the medical students are expected to move from being "novices" to the "expert" level within their attachment. What therefore is a point of interest from

the perspective of ethnographical research is that the stage model can analytically support the empirical description of (a) what, in the field of psychiatry, is expected of the professional at the expert level and what is expected of the students at the novice level and (b) how the progression of students is performed during the attachment.

The Ethnographic Approaches

As mentioned above, the context of learning for a medical student in psychiatry is unexplored. To understand the main learning conditions for students during their clinical attachments in psychiatry, it is necessary to have a description of the daily practices at a psychiatric hospital ward and the embedded learning situations within these practices. Ethnographic fieldwork is developed to capture daily practices (Borgnakke 1996; 2013; Hammersley 1983) and can capture the situated learning, the complexity of the field and the use of the video library in real time.

In the study, ethnographic fieldwork, approached as participant observation, is used to create close-up research of the unfolding of apprenticeship practices, the learning situations at the ward and the experimental use of the video library. With situated learning as a basic concept, the focus in the observations is the medical students trying out practical professional doings and interactions during their attachments. By covering the newcomer's participation in the daily practice, it is also possible to generate a detailed description of how a video library is used as a supplementary learning tool during apprenticeship, which will be the foundation of the analysis.

Inspired by the ethnographic analysis of learning processes and exemplary situations in the scholastic and clinical context (Borgnakke 1996; 2005; 2014; Røn Noer 2016), the goal is to zoom in on the clinical procedures and routines in the ward as the professional learning context, the original situations and articulated sentences to be described in relation to the practice are carried out. The field observations are sampled mainly from situations in the inpatient wards and the psychiatric emergency department. Field notes are used to hold the practice carried out during the medical students' attachment. To complement the fieldwork, group interviews with the students are completed at the end of each attachment.

The Observed Newcomer Situation

In 2016, the medical students were followed by participation observations periodically during their three-week attachment to cover the learning context and course and to get an impression of the setting in which the video library was applied. The observations focused on the apprenticeship as a daily practice and were followed up by conversations with the students. In addition, a tested pilot version of the video library was observed and, at the end of the attachment, the students were interviewed about how they had used the video tool.

Although the focus is the psychiatric clinical attachment, the medical students' lectures in the week before the attachment were observed to cover the context and the shift between the scholastic and clinical context. In the period of the observations, the medical students were observed dur-

ing the first day of their attachment in the Psychiatric Hospital Slagelse while they were introduced to the hospital, the video library and the mental state examination. In this sense, the starting position was covered by referring to all of the medical students in the attachment. During three different periods of attachment, four students volunteered as key informants and were followed in the daily routines to gain details and materials referring to the course as a whole and to the different contexts the student moved between.

Where the handwritten field notes cover as much of the talk and activities on location as possible and the richness in field notes is the research point, the recorded interviews are more focused and thematized. The medical students were interviewed in small groups of two to three students at the end of their attachment to give further perspectives to the participant observations. The interview followed a semistructured interview guide (Kvale 1996) and had three themes: the overall attitude toward the students' attachment in psychiatry, learning situations during the attachment and the students' use of the video library.

On the described backdrop, the fieldwork meant following the students every day during the attachment from the time they arrived at the hospital up until the point of leaving. The following of the medical students' days at the hospital made the structured practice and professional everyday life visible. The day starts by attending the morning conference. Afterwards, they go to the home ward. At the ward, the students prepare themselves for patient encounters or just wait for the morning meeting to start. As illustrated below, the daily

routine challenges the students and the students' use of the video library challenges the research.

The Routine of Psychiatry Practice

Undertaking the fieldwork meant following the students every day during the attachment from the time they arrived at the hospital up until they left. The medical students' days at the hospital mostly followed the routine of the ward: starting the day by first attending the morning conference and then going to the homeward. The students were connected to a homeward – if possible, only one student was connected to each ward. Then, students prepared themselves for patient encounters or just waited for the morning meeting to start 8:30 AM. After attending the meeting, the students would often try to ask a doctor at the ward about what to do. Depending on the doctor's answer, the time until the noon conference would be booked with various tasks. The students read the medical records of the patients, prepared for patient interviews, looked up medicine at the computer database or asked nurses if they could suggest patients with whom they could talk, do patient interviews or if there were any interviews they could observe and so forth. Sometimes, if they have participated in a patient interview on their own or with a doctor, the students would take short notes in the patient journals.

At noon, all doctors and students would again attend a conference at which the histories of new patients would be presented; it would also be decided during those conferences whether the patients should be transferred to the stationary wards and, if so, which of the wards should receive

them. Afterwards, most of the staff go for lunch and the students meet to have lunch together. After lunch, the students often go back to their wards to finish what they had been doing or try to find a patient to talk to unless group instruction is scheduled for the afternoon.

The following example of the participative observation illustrates the newcomer's situation. The student is supposed to participate as part of the staff group. But as seen below, the student has no clue what to do and who to join.

E and I walk into the staff office. There is only a few staff present, and E and I say hello. E asks if there is a meeting for the doctors. A woman, who introduced herself as the secretary, answers that there is a patient meeting in the TV room. She says the meeting is every day between 8:45 and 9:00 AM (the time is now 8:53 AM). E asks if she can go there. The secretary confirms this and inform us that the senior psychiatrist is not present on Tuesdays. A woman comes in. She is a psychiatrist. E and I greet her and E says she wants to go to the patient meeting. The psychiatrist says it is for patients and staff and, "you shouldn't go—they won't like it." E looks confused.

The psychiatrist looks at some papers. E and I sit down at a long conference table and wait. We are facing an electronic screen showing an overview of the patients. "Oh, they've been in here for a long time," says E, looking at the screen.

(Fieldnotes, March 8, 2016)

With no clue as to what to do and who to join, the example shows the newcomer situation. The example also shows how the conversations, the setting, people, and actions generate the uncertainty and insecurities of the newcomer and witness the complexity of the learning context. In this

sense, the observation is very close to the complex practice of learning learning and hereby closer to the learning situations than any other methods.

With the above example, the complexity of practice learning is illustrated as a non-formal learning situation. In the next example, we illustrate what we count as a more formal learning situation. Referring to the video library, the characteristic compensatory dimension means that the students get the possibility to study the psychiatric patient. By watching the videos, the students are supposed to focus on the patients and observe and note the characteristics of symptoms, such as the mimic, contact and content of the conversation. But as shown below, the student's focus, when watching the video, is not on the patient but on the doctor.

10:23. They watch videos. S takes notes and laughs. F has opened her ICD10 (book with diagnosis) and reads while the video is running. F also has the plastic cards with Risk Assessment lying in front of her. 10:30. F is done watching the video and has problems minimizing the picture of the video so she can see other things on the computer screen at the same time.

10:32. S: "Peew! ...I think I should have seen this video before we went to that guy (patient she interviewed the day before), because there were many questions (asked by the doctor in the video) I could have asked him, which just didn't occur to me" [...] she concludes: "Watch the video before and then go and talk to a depressive patient."

F asks S which questions she thought were good, because F could use them before she is going to talk to a patient at 11 o'clock. S plays forward and back in the video to find the good questions again and to repeat the questions she thought were good

(she can only find two at the moment). S repeats after the doctor: “Can you tell me what feelings you have in you?” [the field notes do not capture the other question]. F seems not to be convinced. S explains that she also thought there were some other questions, but can’t remember or find them at the moment. S: “I can’t even find something concrete – she’s just good at asking, I think.”

They speak about the patient in the video. They talk to each other over the desks.

(Fieldnotes, October 20, 2016)

With this example, the complexity of what we call the compensatory and more formal learning situation is illustrated. The students are formally instructed to focus on the patient, but, as seen, the student’s focus is on the doctor asking good questions. The situation seems to be as follows: two students are, while they are watching the patient video together, getting more and more focused on the doctor’s questions. In this sense, the learning situation seems to revolve around learning how to ask good questions from a doctor and not around the patient.

Summary

The ethnographic approach is able to focus and to elaborate on the important question about how the medical students enter psychiatry as a discipline and as a professional practice. The examples point to the methodical benefit, the challenge and to the limitations of the context of the study. Though the more scholastic part of the students’ course in psychiatry was observed, the study only captures the medical students in a very short period of their six

years of university education. Even though the focus of the study is learning during the attachments in psychiatry, the students’ general experience from their many years of scholastic lectures and earlier attachments as well as the general attitude at health education toward psychiatry must influence the students’ approach to their attachments in psychiatry.

Summing up, we have presented an empirical study of the complex learning context for medical students in a psychiatric hospital and the implementation of a video library in this context. Basically, the learning situation for medical students in clinical attachment is that learning is not formalized but integrated in the daily practice. In this sense, students learn psychiatry by participating in the daily practice, pointing to the importance of taking part in practices to be able to understand professional techniques, treatments processes, relations to patients and social relations characteristic for the ward.

The learning situation, in case of the video library, is different and should be regarded as blended learning and as a learning tool with a compensatory effort, meant as a help to enhance the students’ knowledge about psychiatric patients. All in all, we will describe the video in use as patient-focused blended learning (potentially linked or related to the patient ward), a living textbook and an academic source suitable for further study. But the main purpose of the video library is still to be understood as a compensatory, patient-oriented learning method meant to fill the gap and meet the challenge for contact with psychiatric patients.

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PSICHIATRIJOS SPECIALIZACIJOS MEDICINOS STUDENTŲ MOKYMOŠI STIPRINIMAS: ETNOGRAFINĖS IŽVALGOS

Cecilie Fog-Petersen, Karen Borgnakke, Sidse Arnfred

S a n t r a u k a

Psichiatrijos medicinos studentų rengimo kokybė atsiduria pavojuje, kai studentams nesuteikiama pakankamai galimybių įgyti praktinių žinių iš patyrusių psichiatrų ir dirbant su pacientais. Siekdami suteikti medicinos studentams, kurie specializuojasi psichiatrijoje, alternatyvią galimybę įgyti praktinių žinių apie pacientus, sukūrėme vaizdo biblioteką. Šiame straipsnyje aprašomas ilgalaikis tyrimas, kuriame tiriamos medicinos studentų mokymosi sąlygos klinikinės praktikos metu, koncentruojantis į stebėjimą, kaip vaizdo biblioteka naudojama kaip papildoma mokymosi priemonė. Tyrime taikomi etnografiniai metodai, kurie atliepia klinikinės praktikos metu kylančius iššūkius. Mokymosi situacijų tyrimo ir eksperimentinio

vaizdo bibliotekos panaudojimo tyrimo pamatą sudaro psichiatrijos specializacijos medicinos studentų kasdienės klinikinės praktikos bei interviu po klinikinės praktikos veiklos stebėjimas. Tam, kad skaitytojui būtų lengviau suprasti medicinos studentų praktikos kontekstą, straipsnyje trumpai aprašomas psichiatrijos studijų organizavimas.

Teorinį tyrimo pamatą sudaro Dreyfuso ir Dreyfuso mokymosi modelis, kuriame išskiriami praktinio mokymosi etapai, bei Lave ir Wengerio koncepcija, pagrindžianti situacinio mokymosi per klinikinę praktiką sąsajas su medicinos studentų, kaip naujokų, pasiekimais psichiatrijoje. Taip pat trumpai pristatomi pasirinktų metodų keliami iššūkiai.

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