WHAT DO CULTURAL MENTORS BELIEVE GENERAL PRACTITIONERS NEED TO KNOW IN ORDER TO COMMUNICATE EFFECTIVELY IN CONSULTATIONS WITH ABORIGINAL PATIENTS?

Dr Darshana Dave, Dr Penny Abbott, M/S Elaine Gordon, Prof Jenny Reath

Department of General Practice

Background
There is little published information about what Aboriginal people think is important to teach General Practitioners (GPs) in order to increase their ability to provide culturally safe health care for Aboriginal patients. Cultural Mentors are respected persons within the local Aboriginal community who have a good understanding of the community’s way of thinking and beliefs, and are in a good position to provide advice which can inform the development of cross cultural training resources.

Aim
To collect the views of Aboriginal cultural mentors on what is important for GP’s to know to communicate effectively within consultations with Aboriginal patients.

Method
Semi structured interviews were conducted with 12 Cultural Mentors working in urban or large rural settings. The interview data were analysed thematically to identify key cultural and communication issues that impact on GP consultations with Aboriginal people.

Results
Important cultural and communication issues that GP trainers and registrars should be aware of in order to provide safe and better health care to their Aboriginal patients will be presented.

Discussion
Improving the cultural awareness of health care providers may assist in reducing disparities in Indigenous health status. This paper identifies important cultural issues that will help GPs and GP registrars to communicate more effectively with their Aboriginal patients and therefore provide better health care.
FROM PAPER TO PRACTICE: WHAT IS IMPORTANT WHEN IMPLEMENTING A TEACHING MODEL IN GENERAL PRACTICE?

Ms Sophie Hennessy¹, Assoc Prof Caroline Laurence¹,²

¹ Adelaide to Outback GP Training Program, ² Discipline of General Practice, University of Adelaide

Background
General practice is experiencing increasing amounts of teaching as well as teaching more learners from across the training continuum (medical student training, prevocational training and GP vocational training). While research using theoretical models of teaching has explored teaching capacity and costs¹, it does not discuss how these models would be applied or do apply in the real world.

This study aims to describe the practical application of different types of teaching models in practices within the AOGP Training Network and to develop guidelines for practices to implement these models.

Methods
A case study design was used to explore the implementation of five different models of teaching in Australian general practice: concurrent same level learners; vertically integrated teaching (two levels; three levels); team teaching; and GP teacher model.

Data will be collected from a variety of sources using different methods. Interviews with practice staff, GPs and learners; patient-completed questionnaires; teaching diaries; and practice service data

Results
We will present the results of the case studies from the six recruited practices identifying similarities and differences between the models. Additionally, we have developed a teaching cost calculator that can be used by individual practices to assess the financial impact of a variety of teaching models.

Discussion
This study provides detailed information on how a range of different teaching models work in a general practice environment and what issues need to be addressed when implementing such a model. This information will inform a step-by-step guide to be available for practices wanting to become involved in teaching or change the way they teach.

References
Background
There is limited evidence of the effectiveness of GP supervision delivered via internet protocol (IP) cameras. In the context of a diverse and dispersed geographical area such as Gippsland (40,000 km²), it is even more critical to deliver training programs that overcome existing geographical and temporal barriers.

Aims
We investigated the effectiveness of IP cameras in two training settings: external clinical training visits and distance supervision for trainee GPs using qualitative techniques.

Methods
We conducted individual and focus group interviews of supervisors, trainees and patients before and after the installation of IP cameras in six regional sites in Gippsland (Churchill, Cowes, Lakes Entrance, Leongatha, Maffra and Morwell). Narratives were deconstructed using broad thematic techniques through which we explored expectations and applications of the technology.

Results
Supervisors and trainees (all of whom have used IP cameras in non-clinical settings) identified obvious advantages in reducing travel time, however they emphasised that any advantage should not jeopardise quality supervision. Participants stressed that personal training visits have particular benefits including “corridor conversations”. Additional possibilities include extension to multi-site practices and specialist involvement. Moreover, trainees identified innovative applications to the supervisory educational process. Patients were responsive and active participants, impressed by the possibilities of such ‘sophisticated’ technology in regional areas.

Discussion
Delivery of training programs by IP cameras has distinct merits and limitations. Training providers must understand their individual contexts and training needs to accommodate this technology in their settings.
CONSULTATION REVIEW: WHAT IS THE EVIDENCE AVAILABLE ON METHODS TO ANALYSE CONSULTATIONS AND PROVIDE FEEDBACK IN THE GP SETTING?

Prof Neil Spike 1, A/Prof Caroline Laurence 2, Dr Jessica Siu 2, Dr Judith Culliver 1, Dr John Buckley 3, A/Prof Rosa Canalese 4, Dr Peter Clements 5, Dr Kate Davey 6, Dr Denise Findlay 7, Dr Lawrie McArthur 2

1 Victorian Metropolitan Alliance, Melbourne, Victoria, Australia, 2 Adelaide to Outback GP Training Program, Adelaide, South Australia, Australia, 3 Central and Southern Qld Training Consortium, Brisbane, Queensland, Australia, 4 GP Synergy, Sydney, New South Wales, Australia, 5 Sturt Fleurieu GP Training, Strathalbyn, South Australia, Australia, 6 Bogong GP Training, Wodonga, Victoria, Australia, 7 WAGPET, Bentley, Western Australia, Australia

Background
The review of a consultation is undertaken by GP supervisors and/or external clinical teachers in the practice setting to determine if the learner has the gained the essential knowledge and skills as they progress to be a competent general practitioner. However, there is limited evidence on the most appropriate and effective method to review consultation in a GP setting.

Aims/objectives
To determine the most appropriate direct method for consultation review, the most appropriate tool to analyse a consultation and models or approaches for feedback.

Methods
Electronic searches on PubMed and Embase was performed using Medical Subject Heading and Emtree terms. Title scans of all retrieved articles (over 3500 articles) were performed and the abstracts of relevant articles were reviewed. A total of 47 articles were within the study scope.

Results
Direct methods of undertaking consultation review identified were sitting in or direct observation and video recording with standardised patients and/or real patients. Each method has its advantages and disadvantages in relation to its validity, reliability, feasibility and educational impact.

The tools to analyse consultations in a GP setting identified in the literature include: Mini Clinical Evaluation Exercise [1, 2]; Davis Observation Code [3], Leicester Assessment Package [4, 5], Maastricht History Taking and Advice Scoring List [6] and Calgary Cambridge Model of Consultation [7]. The Five Steps Microskills [8, 9] is the most evaluated model reported in the literature.

Discussion
There is a paucity of evidence on the most effective methods for undertaking consultation reviews, tools to assess a quality consultation and approaches to giving feedback to learners within a GP setting. Further research on this area is required to inform PD in this area.

Reference


