THE "TANDEM" EXTERNAL CLINICAL TEACHING VISIT - A TOOL FOR REMEDIATION?
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GP Synergy - New England/North West

The New England/North West node of GP Synergy (formerly NEATS) is relatively new to the process of remediation. Many of our GPRs are on a 10 year moratorium, giving us limited options for undertaking the remediation process, and no specialist remediation practices are in our area. In 2010 we are trialing a system of “tandem” External Clinical Teaching Visits as part of a GPR’s remediation plan.

The GPR has predominantly communication problems, finding it difficult to show empathy with the patient, and often missing cues (both verbal and non-verbal) that the patients were giving. These included friendly humorous remarks, expressions of pain or discomfort, and indications that they hadn’t understood advice/explanations. In addition, at times he “thought out loud” sometimes alarming the patient as he went through (to them) the list of possible differential diagnoses (so every mother with a child with a rash heard that it “could be meningococcal disease”).

The idea of the tandem visit is to try to given the GPR immediate feedback not only from the medical educator (ME), but from the patient, about the effectiveness of their communication.

It is quite “time costly” involving twoMEs, doubling the cost of each visit. The session is set up much like a routine ECTV, with one ME sitting in on the consultation. The second interviews the patient after they have left the consultation room, and is therefore “blinded” about the consultation that has just taken place.

We have used a combination of a questionnaire, and open ended questions for the patient. Typically, this interview only takes 5-10 minutes, and all of the patients have been happy to be interviewed.

While this process is taking place, ME1 is debriefing the consultation as usual. When ready, ME2 joins them, and is able to give feedback from the patient’s perspective. We hope that by doing this, they may more rapidly gain insight as to the effect that their communication and consultation style has on the patient.

To date, the process has underlined the extent to which the GPR is not effectively communicating with the patient, and the immediate nature of the feedback, and the fact that it is from the patient, makes it far more difficult to attribute to the whim of the individual ME. Initially, we had hoped that it might be possible that the second visitor could be a non-medical staff member, but it became clear quite early that the interviewer needed medical knowledge in order to ask the right questions to gauge whether the GPR had sufficiently taken an appropriate history and develop a management plan.

It also became clear that the questionnaire was not an adequate substitute, as patients were eager to please, and rated the doctor highly on attributes such as communication skills, even when they admitted that they had no idea what they were to do from there on, and had gained almost no new information from the consultation.

Subsequent to the first visit, we are piloting the use of the tandem visit as an early intervention strategy for a GPR identified very early as potentially having communication problems.
WHAT LIES BENEATH - THE CONTENT OF GENERAL PRACTICE REGISTRARS’ CONSULTATIONS: THE RECENT (REGISTRAR CLINICAL ENCOUNTERS IN TRAINING) STUDY

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Background: Patient encounters are the core learning activity of Australian general practice training. However, exposure to patient demographics and presentations is variable between registrars. This may affect quality and comprehensiveness of training. We aimed to identify the clinical and educational content of GP registrar consultations and compare this to national GP clinical activity data.

Methods: This was a cross-sectional study (and pilot for a cohort study). Registrars from a single regional training provider (RTP) contemporaneously recorded (via a paper-based system) details of 60 consecutive consultations. Registrar and practice demographics were elicited by questionnaire. Problems managed were coded with the ICPC2-plus classification system.

Results: Thrity-two of 33 eligible registrars participated and returned 1919 encounter forms. Patient mean age was 42.0 years (37.9% male). Mean consultation length was 16.95 minutes. Most common ICPC-2 disease chapters managed were respiratory (10.5%), musculoskeletal (9.3%) and cardiovascular (8.5%). Investigations were ordered at a rate of 77.4 (pathology) and 15.1 (imaging) per 100 consultations. There were 105.6 medications prescribed, 13.4 specialist referrals and 0.8 hospital referrals per 100 consultations. Supervisor advice was sought in 10.0% of consultations.

Discussion: Registrars, compared to vocationally-registered GPs, saw a younger patient demographic, conducted longer consultations, ordered more tests, wrote more prescriptions and referred patients to specialists and hospital more frequently.

Consultation data has utility for individual GP registrars as a formative assessment tool and for the training provider for program evaluation and quality assurance. The study also provides a ready platform for registrar-driven and other research.

GP REGISTRAR CONSULTATION DURATION: ASSOCIATIONS AND IMPLICATIONS FOR TRAINING

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Background: General practice consultation duration is of relevance to workforce planning and has been consistently linked to consultation “quality” — recognition and management of psychological problems, optimum management of chronic disease, patient-centredness, delivery of preventative healthcare, quality of prescribing, and better clinical notes.

No studies have examined GP registrars’ consultation duration, despite vocational training being when career-long patterns of practice are established. We aimed to establish the duration of registrar consultations and associations of consultation duration.

Methods: A cross-sectional study (and pilot for a cohort study). GP registrars from a single RTP contemporaneously recorded details of 60 consecutive consultations (including duration, recorded to the closest minute by reference to registrars’ clinical software’s timer). Registrar and practice demographics were elicited via questionnaire.

Results: Thirty-two of 33 eligible Term 1 and 2 registrars participated and returned 1919 consultation forms, 1788 containing consultation duration data. Descriptive and univariate analyses showed median consultation duration to be 15 minutes. Mean duration was 16.95 minutes. Longer consultations are associated with working in larger practices, being Australian-trained, being Term 1, working part-time, identifying more psychological illness, and the patient being new to the practice (but not new to the registrar). Involving a supervisor and generating learning goals are associated with longer consultations.
Discussion: Our results show important differences to vocationally-qualified GPs’ consultation duration. An understanding of the determinants of registrars’ consultation duration is important in resource allocation and planning. It is also important to RTPs in the design and organisation of training directed at quality of consultations.

DO YOU SEE WHAT I SEE? DEVELOPING A CONSULTATION FEEDBACK REPORT AS A NOVEL FORMATIVE ASSESSMENT TOOL FOR REGISTRARS
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General Practice Training Valley to Coast

Background: Clinical encounters are the core learning activity of general practice training in Australia. Ideally, the content of each registrar’s clinical experience during training should be similar to that of vocationally registered GPs. However, exposure to different patient demographics and presentations is highly variable from one registrar to another. Collection of clinical data has been used in the undergraduate setting as a tool for reflection and feedback, and to measure achievement of educational objectives.

Objectives: To design an educationally effective feedback report for GP registrars based on their individual consultation content. The aim is to allow comparison of their data obtained from the ReCEnT study to that of their peers and vocationally registered GPs, giving them the opportunity to reflect on the differences.

Method: Data was obtained from the pilot of the ReCEnT study. Through a consultation process priority areas were identified for presentation in registrars’ individual reports — these included patient demographics, problems encountered, duration of consultation, investigation rates, prescribing and referral practices. Comparisons were made to the overall registrar cohort, as well as VR GPs, and graphically displayed in line with best practice. Registrars received the report via email and then discussed it with their training advisor. A formal evaluation of the process will be undertaken.

Discussion: The consultation feedback report acts as a novel formative assessment tool. It allows registrars and medical educators to identify gaps in clinical exposure and implement strategies to address these. Future feedback reports will be adapted according to evaluation findings.

Wednesday 8 September – Paper Presentations 2B

WHERE ARE THEY NOW? CAREER OUTCOMES FOR PARTICIPANTS AFTER 8 YEARS OF UNDERGRADUATE AND POST GRADUATE EXPERIENCE OF ABORIGINAL MEDICAL EDUCATION IN THE KIMBERLEY.
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The Kimberley Aboriginal Medical Services Council and its network of Aboriginal health services have taken a prominent role in regional medical education since 2002. The Rural Clinical School of WA, which is co-located with KAMSC in Broome and DAHS in Derby, has grown from one student in 2002 to 11 students per year since 2007. The PGPPP through ACRRM and now GPET has grown from two places in 2002 to 18 in 2010, and the GP registrar program through WAGPET has grown from no registrars working in Aboriginal health in 2002 to an average of 17 full time six month terms per year across the Kimberley from 2008-2010.

Many of the participants in these programs have returned to the region and others now have inspiring careers elsewhere in Aboriginal health. This paper, using a combination of quantitative and qualitative measures examines the early career paths of the around 120 people who have been participants in medical education in the Kimberley and how they are contributing to rural and Aboriginal health in general, and Kimberley health care in particular.
SUCCESS IN INDIGENOUS HEALTH TRAINING FOR REGISTRARS

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Successful and sustainable Indigenous health training for GP registrars occurs when regional training providers and Aboriginal Community Controlled Health Organisations work in partnership.

Proven Indigenous health training posts immerse registrars in a multifaceted training experience designed to develop the knowledge and skills required to work successfully in Indigenous health. A holistic approach consistent with the Indigenous view of health is a key feature. Registrars are mentored by and become part of the Indigenous health team. They learn from a diverse range of team members including Aboriginal health workers, nurses, GPs and visiting specialists but also gain valuable insights through exposure to programs specific to Indigenous health services such as Link Up, focussing on Stolen Generation issues, and Indigenous counselling services.

Indigenous cultural awareness is an underlying theme in all teaching, setting such placements apart.

Vertical integration of teaching commonly occurs in Aboriginal health training posts with registrars teaching medical students, PGPPP doctors and Aboriginal health workers.

An exciting development in recent years has been the involvement of Indigenous registrars in cultural awareness training, enhancing teaching for other registrars. Teaching by Indigenous registrars may also extend to supervisors and medical educators.

The above are key elements in the successful partnership between Adelaide to Outback GP Training and Nunkuwarrin Yunti of SA, which since 2003 has seen 12 registrar placements. This training post is consistently filled due to high registrar satisfaction.

The prime measure of success, however, is the number of Nunkuwarrin Yunti registrars who have continued to work in Indigenous health upon graduation with their FRACGP.

COLLABORATION OVER TIME – PRODUCING OUTCOMES

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Since 2005 the School of General Practice, Rural and Indigenous Health at the Australian National University Medical School and CoastCityCountry Training (CCCT) have been working collaboratively through the Aboriginal Heath Medical Education and Training (AHMET) Committee to deliver a vertically integrated Aboriginal health training pathway. The AHMET Committee comprises CCCT, the ANU Medical School (ANUMS), Winnunga Nimmityjah Aboriginal Health Service (Winnunga) and Katungul Aboriginal Corporation Community and Medical Services (Katungul). This paper will describe the success this partnership has achieved.

The partnership between the organisations has seen the steady supply of GP registrars to AMSs in the region consolidate since 2005 and an increase in medical student places within Aboriginal medical services also. Over this same period of time there has been reciprocal teaching and clinical support. Winnunga staff teach directly into ANUMS and CCCT programs, and a number of ANUMS/CCCT staff provide clinical services at Winnunga.

Through the support and partnership with ANUMS and CCCT, Winnunga was awarded a LIMELight Award in 2007 at LIME Connection II for its program Leading innovation in community engagement.

A further development of the partnership with the ANUMS, Winnunga and Katungul has seen the development and implementation in 2010 of an Indigenous Health Stream into the ANUMS. The vision of the Indigenous Health Stream is to produce a medical workforce skilled in delivering Indigenous health to the region. The Indigenous Health Stream seeks to contribute to a strong vertically integrated medical education and career pathway in Indigenous health in the region. In 2010 PGY2 PGPPP places at Winnunga will also commence to support this pathway.

The strong partnership between the organizations in the region allows for vertical integration from medical school into general practice training for those doctors who wish to pursue a career in Indigenous health. This paper will describe this partnership and the implementation of the indigenous health stream at the ANUMS.
INDIGENOUS HEALTH TRAINING IN METROPOLITAN MELBOURNE - HOW DO YOU DO THAT?
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Victorian Metropolitan Alliance

This paper is a real time exploration of the development of a metropolitan Indigenous Health Training Program. Indeed the answers to the question posed in the title are certainly not fully known at the commencement of writing. Therefore this paper will be developed in several parts over the coming few years to answer in an evidence-based chronicle how we can provide effective, engaging and stimulating Indigenous health training.

Our first task is to identify what registrars need and require that we are not currently providing. Issues raised by registrars point to a perceived lack of relevance in major metropolitan practice, repetition of background culture and history knowledge taught at university, lack of real life case discussions and limited contact with Aboriginal and Torres Strait Islander people.

A suite of measures is being developed to satisfy curriculum requirements and to address these registrar concerns that include orientation workshops, small group case discussions with indigenous representation, clinically and culturally based self directed learning projects, and integration of Indigenous health issues into main stream discussions. Limited short clinical placements in an Aboriginal medical service are proposed for those with a further interest.

Successes and difficulties of our program are presented along with evaluations of the various activities by our registrars.

We invite those interested in other RTPs to journey with us and share through discussion and feedback, our and other RTP experiences, ideas that may work for us and other settings also.