

SUSTAINING A GP TEACHING WORKFORCE - WHAT MOTIVATES GPs TO TEACH

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Sustaining a future GP teaching workforce will be crucial with increasing numbers of medical students, junior doctors and GP registrars training in general practices. The 3Rs to sustaining a GP teaching workforce – recruitment, retention and reformation are examined with particular emphasis on exploring factors that motivate GPs to teach.

This paper will give a progress report on results of action research funded by CoastCityCountry Training and being undertaken by the School of General Practice, Rural and Indigenous Health at the ANU Medical School.

The study is identifying and exploring factors that motivate GPs to commence and continue to teach through a qualitative in depth interview technique with motivational frameworks previously identified by Maslow and Hertzberg being used as a basis for questioning. Findings will be tested with GP teachers in focus groups to develop new strategies for GP teacher engagement based on research findings.

DEVELOPING CULTURALLY COMPETENT SUPERVISORS (AND HEALTH PROFESSIONALS)

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Developing culturally competent health professionals is emerging as an important issue in Australia due to an increasing number of culturally diverse patients and medical workforce. Research has shown that increased cultural competence of health practitioners is linked to greater patient compliance and satisfaction [1]. This can also be applied to cross-cultural supervisory relationships where the supervisor and the supervisee are from different cultural backgrounds. Cultural competence in supervision is defined as the knowledge, skills, attitudes, and judgements, supervisors need in order to interact positively with supervisees from diverse cultural backgrounds [2].

It is widely accepted that cultural competence training programs should encompass the development of attitudes, knowledge and skills and also acknowledged that cultural training programs can effect positive change in participants' attitudes and behaviour when engaged in cross-cultural encounters [3]. However, there are no generalized guidelines as to the most effective way of developing cultural competence training programs for health professionals and there are few empirical studies which evaluate the effectiveness of training programs.

This paper will outline the development and implementation of an eight hour interactive cultural competence training workshop designed to improve the cultural competence skills of 75 GP supervisors, many of whom were engaged in the cross-cultural supervision of international medical graduate registrars. The training day was evaluated using the Inventory for Assessing the Process of Cultural Competence among Health Professionals – Revised [4] which participants completed pre-training, immediately post-training and six months post-training.

Results from statistical analysis of the data showed an improvement in overall cultural competence scores for the group immediately post-training and this was maintained six months later. Analysis of the constructs of the IAPCC-R showed statistically significant changes in cultural knowledge, cultural skill and cultural encounters from pre-training to post training and these changes were also maintained six months post-training.

This study showed that the format and content of the cultural competence training program was effective in developing the cultural competence of the GP supervisors. It also provides a format which can be easily adapted to develop cultural competence skills in other groups such as registrars, consultants, allied health workers, health administration personnel and undergraduate medical students.

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- [3] Beach MC, Price EG, Gary TL. Cultural Competence A Systematic Review of Health Care Provider Educational Interventions. *Medical Care*. 2005;43(4):356-73.
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A THEMATIC ANALYSIS OF GPEP2 EDUCATORS RECOGNITION OF SENIOR REGISTRARS CULTURAL SAFETY WHEN CONSULTING

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The discrepancy of health outcomes between Caucasian and Maori New Zealanders has been well documented. It has also been shown that Tauiwi general practitioners are resistant to change that will improve health outcomes for Maori at a population level. One factor in this is that doctors may not recognise the importance of being culturally safe when consulting with Maori. This study has been designed to see if cultural competency is recognised as a core component of the necessary skill set a general practitioner needs to obtain the FRNZCGP qualification.

GP educators and assessors for the RNZCGP were asked to make written comments on a role play of a registrar consulting. This consisted of what the registrar did well, what they could have done differently & what advice or resources they would offer the registrar to change their practice.

The role play viewed was of a senior general practice registrar performing a first antenatal consultation with a wahine. The role play involved the registrar having a good knowledge base and good patient centred consulting skills. The registrar however was instructed to ignore all cultural Maori beliefs around child birth and Maori health beliefs in general.

The written comments of the educators and assessors will be subjected to a thematic analysis. This will firstly show if they pick up on the cultural aspects which were lacking in this role play. It will also allow them to show their knowledge of what support and education is available for senior registrars to enhance their cultural competency skills. It will also show if there is a need for training of all general practitioners in the importance of cultural safety as part of the requirements for obtaining and maintaining the FRNZCGP qualification.

KAKADU TO JALI - A GP'S EXPERIENCE OF 27 YEARS IN ABORIGINAL HEALTH IN THE NT AND 1 YR IN NORTHERN NSW

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I commenced my long hard road in Aboriginal health in 1983. I was the first doctor to work for the newly formed and proud Gagadju Association in Kakadu. Fifteen years later that organisation was bankrupt and disbanded, its chairperson deposed. I only lasted eight months, burnt out and limped into Darwin. I wrote a Master of Public Health thesis on the children in another Aboriginal community, realising "band aiding" and one-to-one clinical care was not the answer.

But something was very wrong with the strongly touted New Public Health of that era in the 1990s. The principles of self determination and empowerment spawned a new Aboriginal controlled health service but also saw the demise of the Aboriginal health worker movement in the 1980s as they were no longer an integral part of health services. They were hived off to an academia that did not understand their apprenticeship, leadership and the strong clinical role they played in the majority of clinics in Aboriginal communities throughout the NT.

I bear witness to the amazing contribution they made in that era and how advocacy for them and all that they stood for was a very important role of the GP working in Aboriginal communities; how imparting any medical knowledge to them was repaid many times over in their generosity in patiently explaining their culture and world view, over and over again.

I went to Cambodia for five years and found many similarities and differences, but empowerment and knowledge were key. The same community I worked in 15 years before was vastly different too on my return. The intervention came and still no improvement.

This is a story of my very limited understanding of Aboriginal health, 27 years on. What do we say to the future GPs who choose the hard road of working in Aboriginal health?

Wednesday 8 September – Paper Presentations 3B

DO CLINICAL LECTURES GIVEN BY GPs INFLUENCE THE CAREER PATHS OF HOSPITAL RESIDENT MEDICAL OFFICERS? - RESULTS OF A POST HOSPITAL CLINICAL LECTURE SURVEY AND GENERAL PRACTICE TRAINING CANDIDATE SURVEY

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Background: Exposure of resident medical officers in Queensland hospitals to general practice is currently limited. The initial years post graduation are a critical time during which doctors make decisions as to their future medical career paths.

Method: The authors of this study have designed a clinical lecture program for hospital resident medical officers delivered by GPs in Southern Queensland. The first phase of surveys are conducted after the clinical lecture by the resident medical officers which asks questions regarding their planned career prior to the lecture, their level of interest in general practice after the lecture and how the lecture has influenced their feelings about general practice as a career. The second phase of surveys will be conducted at the time of interview for general practice training positions. The goal of the second phase survey is to find out if they attended any of the lectures given by GPs in this lecture series and whether the lectures influenced their decision to choose general practice as a career.

Results: To date 20 first phase surveys have been completed. The goal is to have at least 100-150 first phase surveys completed before the 2010 GPET Convention. The data to date demonstrates: improved confidence in those who had considered or chosen general practice as a career; those who had not chosen any medical career path can be influenced to consider general practice as a career; and those who have chosen other specialties can be influenced to consider general practice as a career.

Conclusions: Although the numbers of respondents to date are small the responses show a positive trend indicating that an intervention in GPs giving clinical lectures to hospital resident medical officers can positively influence their decision to choose general practice as a career. The rest of the surveys will be completed by the 2010 GPET Convention.

WHY CHOOSE GENERAL PRACTICE?

Mrs Pauline Ingham
Rural Workforce Agency Victoria

VicNet, the Victorian RTP consortium involved in Victorian State AGPT Marketing, has surveyed new entrants for the past five years exploring the influences - personal, professional and marketing – that impact on a general career choice. This paper explores the range of influences and its implications on marketing and recruiting into general practice.

Data has been collected over five years from two sources: Victorian AGPT new entrants and attendees of VicNet hospital seminars promoting the AGPT program in Victoria including both medical students and prevocational junior doctors (PGY1-7)

VicNet's marketing program's goal is to build awareness of AGPT to the prevocational doctor market. Promotional events in Victorian hospitals are the major focus however these are supported by a range of other marketing activities. Over the five year period over 100 promotional events were held with approximately 3,000 face-to-face presentations made. Trend data from hospital seminar evaluations consistently indicate the majority of attendees rate the information as "new to them", giving VicNet confidence that state marketing efforts were effective.

The outcomes for VicNet over the five year period have been an increase in applications and a record number of training places (96.63%) being filled in Victoria in 2010.

In addition to Victorian state marketing, there were many other factors at play during the five year period 2005–2009:

- Change in government to Labour November 2007 and their focus on Health Reform
- Commonwealth increased number of training places (each year from 2008 onwards)
- Increase in applications for AGPT nationally and in Victoria
- Increase in training places filled for AGPT nationally and in Victoria
- Constant level of media coverage on medical workforce shortages
- The entrance of Generation Y into the hospital environment.

How much of the 2010 success is due to the state marketing VicNet undertakes? How much of the increase would have occurred regardless of marketing activities?

The VicNet new entrant trend data reveals the top three reasons for choosing general practice, looks at the impact of marketing activities on a GP career choice and also looks at decision timeframe. Exposure time in rural environments is considered in pathway choices. The emergence of doctors from medical student "GP pathway programs" is also considered.

VicNet must now consider whether past performance will be an indicator of future success in the recruitment for general practice training. Will the current strategies be appropriate in an increased target market and with a new generation of doctors entering their prevocational hospital years?

DOES RURAL MEDICAL EDUCATION ADDRESS THE RURAL MEDICAL WORKFORCE NEEDS?

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Queensland Rural Medical Education

In 1999, Jack Best authored the Rural Health Stocktakeⁱ which identified that one year beyond the 1997 and 1998 cohort of national Registrars (n=400 Registrars per year) only 35 Fellows were practicing in rural locations. With regionalization the AGPT program now includes a number of new rural-based programs.

Factors known to be related to ultimately choosing rural practice include geographic location prior to entering medical school, having a partner with a rural background, an extended rural undergraduate experience and a specialty preference for general practiceⁱⁱ. The rural pipeline model suggests that efforts need to be made from high school through to vocational training to provide positive rural medical education experiences to increase the likelihood of rural medical career choicesⁱⁱⁱ. Rural clinical schools providing positive rural training experiences towards the end of the undergraduate program appear to change the intent to practice rurally, but intent is compromised by perceptions of professional support in rural environments^{iv}. Early postgraduate rural placements seem to translate into rural practice^v.

However, there is limited evidence as to whether vocational training programs conducted in rural locations translate into retained rural practitioners.

QRME (formerly RRQC) delivers a rural specific training program delivered by rural practitioners in their communities. Since inception, as at the beginning of 2009, 56 Registrars have completed training at QRME/RRQC. The location of practice of these Registrars has been traced. **Of these Registrars, 58% are practicing in RRMA3-7 areas in 2010.** The Rural Retention Rate of QRME/RRQC compares very favourably to that which existed prior to the establishment of rural medical vocational training.

5 YEARS OF PGPPP WHERE ARE THEY NOW?

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Northern Territory General Practice Education

Background: NTGPE has been running a very successful GP placement program since January 2005. The inclusion of interstate program participants in 2008 saw an increase of junior doctors with a wide range of career interests and goals

Aim of presentation: To look at what junior doctors are doing now and how doing a PGPPP placement in the NT influenced their career pathway.

Relevance: We know how importance the program is in enabling junior doctors to have a taste of general practice, but does it influence their decision into other career pathways that prior to their placement were not on their career radar.

Methodology: NTGPE has kept a data base on all junior doctors and will contact all previous program participants to see what they are doing now and how the NT placement influenced their decision.

Outcomes: Over the past five years NTGPE has found that many junior doctors that come and do a placement have not had an interest in Indigenous health or general practice. After completing their placement a new interest is ignited and many planned on coming back to the NT at some point in their career.