HARD TO REACH IS NO EXCUSE: THE USE OF THE VIRTUAL CLASSROOM FOR SYNCHRONOUS MEDICAL EDUCATION OF REMOTE GENERAL PRACTICE REGISTRARS

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Northern Territory General Practice Education

In 2009 the Northern Territory regional training provider for general practice education had approximately eleven registrars placed in four different remote settings in the top end of the Northern Territory—most of which were Aboriginal Health Posts. None of these locations had onsite medical educators but three of these sites had registrars that were at points in their training that required protected release time for face-to-face learning as per RACGP policy. Good quality, consistent and reliable education was requested by the registrars. In order to meet these requirements the Wimba classroom, a type of educational collaborative software, was introduced to the remote registrar group in September and used to deliver small group learning. A guest lecturer is invited to speak to the registrars about a topic developed from the curriculum using this online classroom each fortnight. Previous solutions had been attempted using the face-to-face stream that runs fortnightly for the urban registrars. Teleconferencing, video conferencing and videotaping the live sessions had all been trialled but all apparently failed. The employment of another part-time medical educator increased capacity and allowed for the release of the Wimba classroom. The use of virtual classroom for the distance education is supported by the existing literature, which suggests students are not disadvantaged by distance education. However, while acknowledging that face-to-face instruction (whether live or virtual) is both valued by students and a requirement of training, synchronous teaching is not the only solution for curriculum delivery for remote GP registrars. That said the success or failure of these online classrooms is arguably critical as anecdotally the perceived quality and consistency of training appears to be influencing the registrars’ decisions to take up remote placements and help to maintain workforce in the NT.

THE SUCCESSFUL USE OF VIRTUAL CLASSROOMS IN MEDICAL EDUCATION

Dr Greg Gladman, Mr Lex Lucas
Australian College of Rural and Remote Medicine

The Australian College of Rural and Remote Medicine (ACRRM) has been using real time virtual classroom technology over the internet for the past two years. The Independent Pathway to FACRRM has been using this technology as one of its key teaching tools in delivering the ACRRM curriculum to enrolled registrars. It allows real-time voice and visual interaction between participants.

Other uses have included accredited Mental Health Level 1 and 2 training and even internal staff meetings.

But it’s not just the technology that has made the project successful. There are all-too-frequent examples of the less-than-ideal use of technology in the delivery of education programs.

ACRRM’s use of the virtual classroom software has rated highly in the satisfaction of both presenters and participants right from the outset.

This session will discuss ACRRM’s unique approach to the successful implementation of the technology, along with its approach to encouraging its use, and subsequent support of its users.

TELEPHONE GA GA OR IS IT CALLED FACILITATION?

Dr Louise Baker, Ms Amanda Hollands, Dr Patrick Giddings
Remote Vocational Training Scheme

The Remote Vocational Training Scheme (RVTS) provides vocational training for remote doctors across Australia and overseas. A large component of this vocational training is done over the phone. RVTS runs 90 teletutorials and nearly 30 study group teleconferences per year and has found that good teletutorial facilitation is a key determinant of successful, quality and standardised education for remote registrars.
This presentation talks about what good and bad facilitation can look like and how to promote the good and prevent the bad. Facilitation training for medical educators and external facilitators is a vital activity. With increasing numbers of new facilitators and the planned growth of RVTS in 2012, a systematised approach to training, supporting and evaluating teletutorial facilitation has become essential.

A system of training new facilitators through the development of a teletutorial Facilitators Handbook (covering tips for facilitating teletutorials, teletutorial etiquette and registrar profiles); teletutorial facilitation audits and feedback; evaluation teleconferences involving all facilitators discussing what went well, what could be improved and learned from each other and feedback into the Handbook has led to a system of quality improvement and a team of well-trained, supported facilitators. The flow on effect has been a standardised approach to RVTS teletutorial facilitation and an improved teletutorial product.

Come along and hear more about how it has been done and tell us how you do it!

STUDY GROUPS BY REMOTE CONTROL
Dr Ruth Johnston, Dr Louise Baker, Dr Bambi Ward, Dr Patrick Giddings
Remote Vocational Training Scheme

The Remote Vocational Training Scheme (RVTS) trains registrars to be GPs remotely. For doctors working in small communities where there will be no or little support, RVTS is a shining light. They support and educate you through your early days of GP training and guide you as you race head long into exams. To this end, the hallmark of study for exams has been the study group, so now we have one too—remotely. How can you have a study group, you may ask, as students hit the books up to 4000km apart? The answer of course is still the humble telephone. Students meet one night a week in the ether of the teleconference to discuss cases, practice MCQs and rehearse their clinical exams. Does it improve outcomes? The examination results seem to demonstrate that it does and as a past participant I can assure you that it makes the lonely journey towards fellowship a lot less lonely. It is a chance to engage colleagues, stretch and augment your knowledge and debrief when it is all over.

OUT OF SIGHT BUT NOT OUT OF MIND? A REVIEW OF THE LITERATURE ON REMOTE SUPERVISION OF GENERAL PRACTICE REGISTRARS
Dr Susan Wearne
Flinders University Rural Clinical School

The apprenticeship model of general practice training, with physical co-location of the full-time supervisor and registrar, has been viewed as sacrosanct. However it no longer matches GP work patterns and perpetuates the maldistribution of doctors to the detriment of rural and remote communities. An alternative of off-site or remote supervision now occurs for varying lengths of time and can occur in the following situations: with part-time supervisors; when registrars conduct branch surgeries or visit nursing homes; for part of training for registrars in the Defence Forces or throughout training in the Remote Vocational Training Scheme (RVTS); in the Australian College of Rural and Remote Medicine (ACRRM) independent pathway; and for doctors in remote areas registered under area of need legislation.

What do we know about what makes remote supervision safe and effective? Is the role of the remote supervisor different to that of the on-site supervisor? What difference does remote supervision make to GP registrars and how they learn and approach clinical problems? These questions will be addressed in a project investigating best practice in remote supervision.

This paper is the first stage of this project, the results from synthesis and critique of the world-wide literature on remote supervision in GP training.
PREPARING FOR AN AGEING POPULATION: A SURVEY OF OLDER PATIENTS’ ATTITUDES TO GENERAL PRACTICE REGISTRARS

Dr Andrew Bonney¹, Prof Sandra C Jones ², Ms Lyn Phillipson ², Prof Don Iverson ³
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Introduction: The ageing population makes it imperative to provide appropriate training for general practice registrars (GPRs) in the community-based care of older patients. However, data suggest that older patients may be less willing to consult GPRs for chronic/complex care; adversely affecting training opportunities and potentially the satisfaction of older patients in training practices. This cross-sectional study was undertaken to investigate this concern in the Australian context and develop models of older patient-GPR interaction that are acceptable to patients.

Method: Ten GP training practices in regional Australia each provided 50 patients aged 60 years and older with a questionnaire for self-completion. The questionnaire included demographic items and Likert-scale items assessing the patient’s attitudes to registrars. Chi-square, Spearman’s rho and logistic regression were used for analysis.

Results: The response rate was 47% (n= 233). Most respondents felt it required time to develop trust with a new doctor (65.8%), and almost all wanted their ongoing contact with their regular doctor preserved if they saw a GPR (96.1%). Twenty-four per cent of respondents were comfortable with having a GPR manage a chronic/complex problem alone; this increased to 73.1% if their usual GP made personal contact during the consultation (p<0.001).

Discussion: This study quantifies a widespread reluctance amongst older Australian patients to GPRs managing chronic/complex conditions, with the potential for a detrimental impact on registrar learning opportunities. Older patients’ acceptance of GPRs for chronic/complex care may be significantly enhanced by maintaining a relational link between patients and their regular GPs around GPR consultations. These results warrant further research.

THE L PLATE PRESCRIBER IN GENERAL PRACTICE: LEARNING NEEDS OF GP REGISTRARS AND BARRIERS TO THE QUALITY USE OF MEDICINE

Dr Nick Cooling ², Dr Jeremy Bunker ³, Dr Rola Ajjawi ³
¹ General Practice Training Tasmania, ² GP Synergy, ³ Monash University

Background: Very little is known about the specific learning needs of GP registrars in Australia in relation to quality use of medicine (QUM) or the difficulties they experience when learning to prescribe. The aim of this study, funded by the National Prescribing Service, was to address this gap.

Methods: GP registrars’ learning needs, across three regional training providers, were investigated through an online national survey, interviews and focus groups. Focus groups were held with GP registrars to explore issues raised in the survey in more depth. Medical educators’ perceptions were canvassed in semi-structured interviews in order to gain a broader perspective of the registrars’ needs. Qualitative data analysis was informed by a systematic framework method involving a number of stages. Survey data were analysed descriptively.

Results and discussion: The most commonly used resources were MIMS, Therapeutic Guidelines and Australian Medicines Handbook. The two most commonly attended QUM educational activities took place in the workplace and regional training providers. Outside of these structured educational activities registrars learned to prescribe mainly through social and situated means. GP registrars modelled their GP supervisors’ prescribing and were influenced by their supervisors, peers, colleagues and pharmaceutical company representatives. Difficulties encountered by GP registrars included the transition from hospital prescribing to
prescribing in the GP context, judging how well they were prescribing and identifying appropriate and efficient sources of information at the point-of-care.

**Conclusions:** GP registrars learned to prescribe primarily and opportunistically in the workplace. Although situated learning is appropriate for learning to prescribe, a more structured approach is recommended. Ways of easing the transition into general practice and of managing the information ‘overload’ related to medicines (and prescribing) in an evidence-based, efficient and timely manner are needed. GP registrars should be provided with explicit feedback about outcomes of prescribing decisions, including the use of audits, in order to improve their ability to judge their prescribing.

**PROCEDURAL SKILLS IN GENERAL PRACTICE VOCATIONAL TRAINING: WHAT SHOULD BE TAUGHT?**

Dr Stephen Sylvester 3, Dr Parker Magin 1,2, Dr Kevin Sweeney 1, Dr Simon Morgan 1, Ms Kim Henderson 1

1 General Practice Training - Valley to Coast, 2 University of Newcastle, 3 Scone Medical Practice

**Background and aim:** Procedural skill training is a key aspect of vocational training for general practice. However, there is no consensus on which skills should be routinely taught to all registrars. We aimed to establish a list of core clinical procedural skills which all registrars undergoing vocational training for general practice should be taught.

**Method:** A two-round Delphi process was used to establish the relative importance of items on a list of 185 procedures derived from a search of curriculums and training documents of national and international general practice educational institutions. In 2009, 63 GPs were invited to take part in the expert Delphi panel. GPs were purposively recruited to obtain a maximum variation sample on a range of factors. In the first round, participants completed a questionnaire in which the importance of each procedural skill was presented on a four-point Likert scale. Comments on each item were invited, as well as nomination of additional skills. In round 2, participants were requested to rescore each item on the basis of mean scores and collated comments.

**Results:** Thirty-one of 63 invited experts agreed to take part and all completed both rounds of the Delphi process. Mean rating scores for all the procedural items listed were determined and used to rank procedures. A cut score was then determined for the Australian general practice context.

**Conclusion:** The ranked list of clinical procedures provides a valuable reference to form the basis of a procedural skills curriculum which can be adapted to different general practice training contexts.

**FIRST CONTACT**

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**Context:** Too often problems with GP registrar (GPR) performance are identified late in their training, leading to problems for both the GPR and the regional training provider (RTP). Many RTPs have developed assessment tools to identify GPRs needing assistance. Rather than reinvent the wheel it was decided to adapt a Pre Basic Assessment from another RTP to specifically assess and identify GPR issues prior to commencing GPT1. This involved a collaborative partnership, fostering links between RTPs, utilising existing knowledge and research and ultimately creating a new tool to provide a baseline assessment of GPR strengths and weaknesses, relevant to the needs of the RTP. Areas assessed included consultation skills, script and referral writing and medical knowledge particularly in relation to safe practice in the form of key feature problems.

**Objectives:** To identify practical, knowledge and communication issues for GPRs early in training so that learning plans could be developed early to reflect both the needs and strengths appropriate to the GPRs’ needs. This also informs the medical educators and GP supervisors of priority areas to be addressed.

**Key messages:** Pre Basic Assessment, safety, assessing competence in regard to practice and communication, RTP sharing ideas and learning from each others experiences.
Conclusions: The Pre Basic Assessment allowed a great deal of information to be gained about the individual GPRs and potential problems were identified early in training and solutions put in place. The process can be time consuming and labour intensive.