# GP MAGIC

Measuring and Growing Inherent Capacity for Learning and Teaching in General Practice in Tasmania Progress Report march to December

Progress Report March 2011

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**Overview of the Project:**

GP MAGIC (**G**eneral **P**ractice: **M**easuring **A**nd **G**rowing **I**nherent **C**apacity – for learning and teaching) is a project aimed to increase Tasmanian general practice's capacity to deliver learning and teaching to medical and other health care providers within general practices.

The project is multidimensional with sub-projects to:

i) iteratively measure the quantity and quality of learning and teaching occurring in general practice,

ii) devise flexible ways to build skills needed for supervision and teaching within practices, and

iii) improve support to teaching practices.

The overall aim is to improve the quality of each general practice's learning environment. All work will be supported by the development of an appropriate digital habitat. Mixed methods have and will be used to evaluate and research the outcomes of the project.


**The diagram above notes the total scope of GP MAGIC related activities in 2010 and part of the future direction in 2011.**

The work of GP MAGIC has many facets. This report concentrates most on the baseline measures taken of current practice activity and the attitudes of practices and supervisors to engaging with learners in their practice.

The end of the report notes developments regarding practice nurse and nurse practitioner training offered by UTAS, and work so far on a prospective study of medical student attitudes to general and rural practice.

## Relevant Literature

As the Australian general practitioner (GP) population ages (Britt H, 2007) and the patient population ages (AIHW, 2008; Britt H, 2007) a need to increase the number of GPs and other general practice health care providers is evident. Tasmania shares the same trends in GP age (General_Practice_Tasmania, 2010) as the rest of Australia and has a patient population that is aging faster than the rest of Australia (AIHW, 2008).

The international evidence notes the need to train more GPs operating in the framework of a primary health care team (De Maeseneer, Willems, De Sutter, Van de Geuchete, & Billings, 2007) but notes an international tendency for medical, and other health, graduates to prefer consultant specialty training (Scott, Wright, & Brenneis, 2004). It has been postulated that health care students may be more attracted to consultant specialisation as it is seen as a "safer environment" than the comprehensive generalist approach of primary care (De Maeseneer, et al., 2007).

In member countries of the OECD (Organisation for Economic Co-operation and Development) there has been a 50% increase in the number of medical consultant specialists over 15 years compared to a 20% increase in GPs (OECD, 2007). In Australia consultant specialists over the last decade have increased from 84 to 116/100, 000 head of population, an increase of 47% (AIHW, 2006).

In the last decade the number of consultant specialists per head of population in training has grown much faster than the number of GP trainees (Calder, 2007; Joyce & McNeil, 2006; Joyce, McNeil, & Stoelwinder, 2006). This runs counter to the evidence on how to improve Australia's health outcomes because we know it produces poor value for money (Starfield, 1998).

In recent decades government policy has actively worked against the growth of the GP population by limiting medical school intakes, limiting intakes into GP training (Calder, 2007), degrading the conditions of work for general practice by, for example, allowing the income for consultant specialists to outstrip that of GPs, and increasing the amount of administrative 'red tape' GPs must comply with (Harris & Harris, 2006). It should be noted that all of these trends follow that of most countries as they develop their health systems. For example a high administrative overload is not unique to Australian GPs with 70% of European GPs reporting the same concern (Boerma & Dubois, 2006).

General Practice registrars have a low rate of attrition from training as do other discipline registrars (AMWAC, 2005) suggesting the problem in attracting General Practice trainees to the profession may be one of piquing their interest to enter in the first instance. The outsider perception of General Practice being less challenging has no evidence to support it (Harris et al., 2007).

Student numbers are now increasing (Calder, 2007) as are the number of training places for General Practice (Roxon, 2008).

We need to be proactive in growing general practice's capacity to deliver health care to Tasmanians. Tasmania's relatively compact nature enhances the chance of the project's success. The desire to develop vertical integration of training for general practice is shared by

GPTT and UTAS. The development of teaching skills in learners at all levels of the vertical continuum will aid this aim. We need to have skilled teachers to continue to expand the skilled general practice workforce.

As the project has evolved in 2010 the early inclusion of nursing professionals in the process has also be pursued as the health care team's importance is increasingly realised (Royal_Australian_College_of_General_Practitioners, 2007). Other non-medical and non-nursing health care providers need to be included onto the project as opportunities allow. For example some practices already employ psychologists, podiatrists, dieticians etc.

## Project Governance and Stages

The project started in 2010 as a joint venture between the University of Tasmania's School of Medicine's discipline of General Practice (UTAS-GP) and General Practice Education and Training's Tasmanian regional training provider, General Practice Training Tasmania (GPTT). Funding came from GPTT and UTAS-GP in 2010 – the majority of funding from GPTT. In 2011, so far, funding has been committed from UTAS-GP only. Funding opportunities from sources aiming to increase undergraduate placements e.g. Health Workforce Australia are being sought but not yet obtained. Funding of a recurrent nature will be required to achieve the project's aims.

General Practice Tasmania (GPTas) was a key project enabler in 2010 giving significant support in terms of access to use of their annual GP census.

Advisors invited to participate in the project in 2010 were:

- Australian College of Rural and Remote Medicine,
- Divisions of General Practice – Northwest, North and South,
- General Practice Registrars Association,
- General Practice Student Network ,
- General Practice Supervisors Association,
- General Practice Tasmania
- Health Recruitment Plus,
- Royal Australian College of General Practitioners,
- University of Tasmania's School of Nursing and Midwifery,
- Tasmanian government's Department of Health and Human Services
- University Department of Rural Health.

In 2010 UTAS-GP led a Tasmania wide engagement with practices to research baseline capacity to offer learning and teaching to mainly medical learners. The results of this effort form the body of this report.

A key meeting of the project's partners on the 9th of March 2011 will lead to the definition of project stages and draft timelines for 2011 and beyond. However future activity is funding dependent.

**The members of the GP MAGIC UTAS project team are**:

*Dr Jan Radford*, Assoc Prof General Practice, Deputy Associate Head, Launceston Clinical School

*Dr Lizzi Shires*, Acting Co-Director, Rural Clinical School

*Dr Emma Warnecke*, Assoc Head Student Affairs, Senior Lecturer, School of Medicine

*Dr Nick Cooling*, Senior Lecturer in Medical Practice

*Debbie Fabian*, Project Manager, ICT in Educational Design, Launceston Clinical School

*Michelle Horder*, Project Officer, Launceston Clinical School

*Jane Macleod*, Project Support, School of Medicine

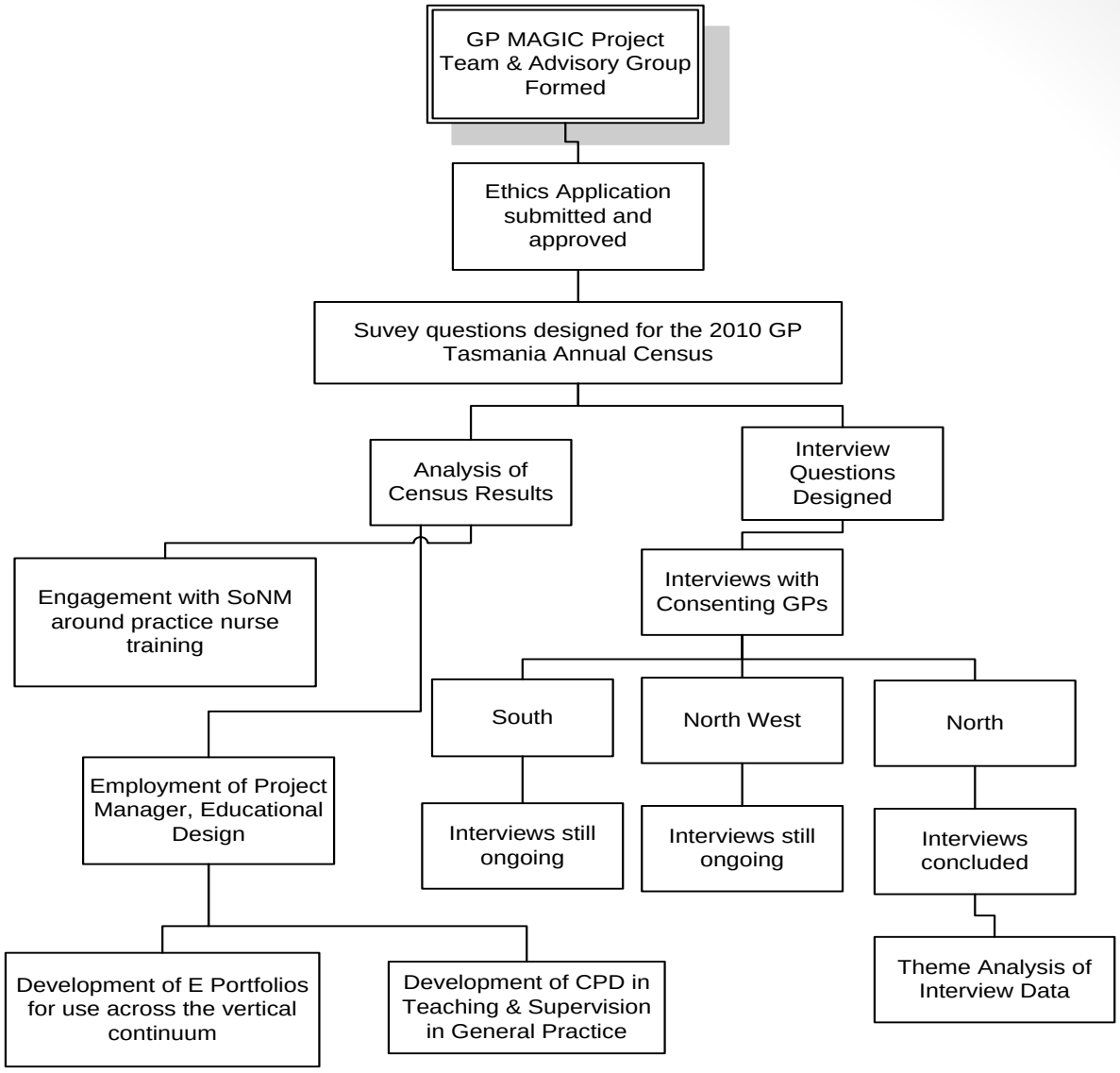
**GP MAGIC's GPTT team members are:**

*Michael Sertori*, CEO

*Dr Jenny Presser*, Director of Training

*Cheryl Street*, Deputy CEO

*Dr Allison Turnock*, Registrar Representative




## Project research ethics

The baseline measurement forms part of a research project lead by Dr Jan Radford. Ethics approval for the research was granted in May 2010 by the Tasmanian Social Sciences Human Research Ethics Committee –project number H11197. The research question was "What factors impact upon the medical teaching capacity of General Practice and general practitioners in Tasmania?"

## Methodology

Baseline data was collected in 2010 via an on-line survey delivered as part of General Practice Tasmania's annual census of general practitioners and general practices. A survey offered the opportunity to sample self-reported teaching activity and interest in future teaching activity in all Tasmanian general practices. The survey also asked for permission to de-identify survey responses to seek permission to approach GPs and practices to participate in focus groups.

**Survey**

The response rate for the GPTas census has traditionally been high so the offer of a limited number of questions for our project was gratefully accepted. This was at no cost to the project. The questions asked in both surveys are attached as appendix c and d.

**Focus Groups**

GPs who indicated they would be willing to participate in focus groups were noted and their practice approached to make a time to talk to them and as many other GPs, practice managers or other staff as wanted to talk to us. The survey data guided the formulation of the interview questions. Questions also explored the brief answers of the survey and asked questions not suited to the survey. The process of running focus groups also assisted in building relationships with practices.

All focus group members provided written consent to participate. See appendix Y for consent information and consent forms. Focus group interviews were undertaken by UTAS-GP academics and project officers in the South and North while in the North West Rural Clinical School academics undertook the interviews. See questions used to guide focus group interviews as appendix X.

The interviews lasted about an hour, the interviews were transcribed, participants were asked to modify transcripts if they felt the need, and the transcripts were then de-identified for analysis.

Dr Jan Radford and Dr Jess Woodruff undertook a thematic analysis of the transcripts to hand by February 2011. This number of transcripts was thought to provide saturation for this analysis

# Results

## Surveys

### 1. General Practitioners

The GPTas census was sent to 570 GPs. The census is a snapshot of general practice in the first week of May 2010.

- 377 (66 %) of GPs statewide responded to GP MAGIC's questions.
- 262 (70 %) of those consented to contact from the GP MAGIC project team, i.e. were willing to be identified, 105 (28 %) did not consent to follow up and 9 (2 %) did not answer the question.

Raw data – see appendices a, b and c

Significant findings from the total cohort (377) were:

- Many practices are interested in having PGPPP and registrar learners in their practices. The names of the practices were available to be contacted if they consented to de-identification.
- Practices in the North West are practically saturated with undergraduates, almost saturated in the North, and some extra capacity was noted in the South, with interest registered for new practices to become involved.
- 91% saw teaching and supervision as their professional duty with 71% noting the financial benefits as not the incentive to teach.
- 83% participated in undergraduate teaching because they hoped to inspire learners to become General Practitioners.
- 34% were interested in increasing their skill level in teaching and supervision.

Many respondents noted the skills training they have already undergone, often via GPTT, or were undertaking, some via the UTAS Grad Cert in learning and teaching. The types of skills respondents thought they would like further training in included:

- "Mentoring"
- "Helping learners identify areas that need work. Evaluating skills and giving feedback"
- "Using evidence-based resources"
- "Help with paperwork and what is expected of supervisors"
- "Have my skills assessed and recommendations offered for improvement/training"

## 2. General Practices

65 practices consented to answer the GPTas census questions. This represented 40% of practices estimated to exist in Tasmania and represented a lower response rate than is normally obtained via GP Tasmania's census.

The following was found:

- 60% saw a need to increase the GP workforce, 30% did not answer the question and 10% did not agree.
- 52% had consulting rooms large enough to accommodate a learner as an observer, 34% did not answer the question and 15% did not have large enough rooms.
- 46% had a consulting room a learner could use to see patients whilst supervised, a few sometimes had this, 34% did not answer the question and 18% did not have a room.
- 40% had a study area for learners, 39% did not answer and 21% did not have this resource.
- 26% felt the financial payments for teaching were adequate, 43% did not answer the question and 31% felt payments were not an adequate incentive.

Enablers to increase current capacity for teaching and supervision were rated as follows:

- 42% felt that increased payments to teach and supervise would assist, 16% thought this may assist, 17% felt it would not assist and 25% did not answer the question
- 48% felt more GPs to share the teaching/supervision load within their practice would assist, 19% felt this would not help and 33% did not answer the question.
- 42% felt more rooms and equipment to accommodate learners would assist, 9% thought this may help, 25% felt it would not assist and 24% did not answer the question
- 37% felt a reduction in red tape would assist, 14% thought it might help, 23% thought it would not help and 26% did not answer the question
- 32% felt increased support from the learners' institutions would assist, 22% thought it might help, 19% thought it would not help and 27% did not answer the question.

Non responders tended to be practices which had not taken learners in the last 5 years or intend to take them in the future.

## Focus Groups

Focus groups have been undertaken in all 3 regions with 11 practices interviewed in the South, 3 in the North West and 15 in the North.

Thematic analysis so far reveals the following issues:

## Accreditation of practices and supervisors for provision of Learning & Teaching

- Awareness of need to be accredited is widespread.
- Often confusion was encountered between the concept of accreditation of a practice to the RACGP's "General Practice Standards" and the practice and supervisors for teaching and vocational training purposes.
- A one stop shop to do this is universally thought to be a good idea.

## Infrastructure

- If more learners such as PGPPP junior doctors enter practices undergraduate students may not be accommodated at all, or their ability to see patients on their own, working them up for presentation to the GP, will disappear, i.e. the quality of their learning experience will suffer.
- Rural doctors want the DHHS to be aware of the need to build consultation rooms for learners when upgrades to community hospitals are planned.

*[what makes it easier to take undergraduates?] "I say this every time, but more rooms'"*

*"If you don't have them in with you the whole time it is a more pleasant experience for everybody, they get to do more and you get a breather, and I actually prefer it if you know they get to go and see someone on their own and then present it to me, then we get together with the patient and all that. I think they get more out of it and I get, you know I can get on with my work a bit more easily in between and you can leave time for that so if you use those teaching on the run, wave models, bizzos then those work. I use that quite a lot, when I can. Off course we can only use that when all the rooms aren't full."*

## Accommodation/ housing for learners (rural)

- Enough housing accommodation for all levels of learners to be associated with the practice all at the same time can be a problem

*"And then we have too many learners all at once the house is full and our Registrars can't stay there"*

## Payment for teaching

**<u>Undergraduate</u>**

- Survey data from practices tended to be more negative than that obtained from practitioners and focus groups.
- As noted from the surveys payment to take undergraduates is accepted as pitifully low but GPs and practices who undertake teaching are not only doing it for pay.

*" ..I don't suppose [the pay is good enough] but we don't even think of it"*

*"Don't think it matters"*

**Registrars**

- The recent 20% increase in payment to teach registrars was not seen as making much of a difference and some practices use practice incentive payments (capitations fees paid to practices) to supplement this low rate of pay to make teaching more attractive.

*"...makes no difference, not one"…."We've always paid, for taking Registrars at a rate we think is reasonable, not what the training program pays us. We basically take it out of the PIP"*

## Benefits of having learners

**Undergraduate**

- A spur to updating knowledge, enhancing the 'able' aspect of being a supervisor

*"….. initially when you're obviously studying for your Fellowship you study a whole heap and then you just get caught up in this mess, trying to just get through the day so you just don't really get on studying anything new so when the students were there I was really looking at getting back and looking at these new things that have actually come on so I was updating my knowledge."*

*"Yeah and then I had to take a step back in my examination and say I've got to do this methodically or otherwise they're going to sit and think, he just did that! (laughter)…. so it got me back to my Taylor and O'Connor looking at all those bits and saying I should be doing this that way maybe"*

- Teaching aids learning in the supervisor and meets a professional need to give to the profession as the teacher experienced in their earlier career.

*"there are two reasons I like teaching, one is because I learn and the second one is I still feel thankful to the good doctors who taught me…"*

- Enjoyment is reported despite service provision interruption

*" I thoroughly enjoy it….you know it takes time out of your day, you've got that sort of thing but it's still, you know worth it"*

*"the actual teaching with a smart, intelligent young student, which most of them are, that's really good stuff"*

**Registrars**

- Registrars can help break down intra-practice silos.

*"You know I think it's good for us to have, you know, GP Registrars around because they keep you on your toes, and you know, have more interaction than we have with each other [usually]. We tend to be in our own little rooms with not much clinical interaction except when a crisis arises or something like that."*

## The attributes of a good teacher

These were commonly appreciated with tips proffered by those with more confidence and experience in the role. These doctors will form the foundation to enhance individual practice's quality of teaching:

- Be aware of the learner's needs and then design learning opportunities to meet needs.
- Provide space and time for students to participate in the practice, consult on their own, either alone or while being observed.
- Junior doctors & basic registrars should sit in with their supervisor to observe consultations and supervisors sit in on learners' consults a lot in their first week – this period gives a chance to see what level the learner is at, to assist in tailoring their learning plans.

*"You have to be creative with whatever level the person's at"*

*"….just personal experience. Letting them actually do some consulting so that in regards to students they have some time with patients on their own or, and/or being observed."*

*"[PGPPPs who are on their first placement and basic registrars] there would be a lot of sitting in, both ways, first up… but you're tailoring the experience to the level the person's at and their personal skills."*

*"A patient and thorough sort of approach to the patients as well as the student, I think that's the main thing. The last thing they want to do is just sit like a fly on the wall and watch you work, they want to be involved and that takes time"*

- Awareness that GP styles vary and an assumption this variety is useful to medical student learning.

*"not keep the student with the one doctor... so they get an experience of different doctors' styles"*

- Exposing learning to the community context of the patients the practice cares for and the subsequent determinants of health

*"…getting them out and about to the [groups in the community]…trying to make it more of a holistic experience"*

- Someone who doesn't leave you just sitting in a corner is a better undergraduate teacher

*"...from experience, because I did some time in General Practice and we were often just sitting in the corner and that's the last thing you want, you don't get anything out of it."*

*"…consulting rather than sitting in. It's not going to cut it being a wallflower"*

- If a student is sitting in with the GP keeping them engaged may be assisted by giving them a task to report on.

*"…at the end of each consultation they're supposed to tell me what the key points were so at least they've got to concentrate".*

Patient acceptance of students was considered high:

*"You only get one refusal from a patient per week to see a student"*

Tips on how better to organise the management of teaching were proffered. The sharing of, trialing, and reflecting upon these tips can form a strong plank for teaching practices skills building.

- Supervisors discuss the progress of learners collectively.
- Using a wall calendar to plot learners in the practice and who is responsible for them on a daily basis is one practice's tip.
- Nominating who will do an OSLER and when with a student, or complete an attachment report should be negotiated at the beginning of the rotation.
- If the learning institution writes a letter to a supervisor the message needs to be contained in just one page.
- All levels of learners should join in practice professional development meetings.
- Group teaching sessions should be organised if the learning needs of learners are similar enough.

Reflection on the view that good clinical supervisors should be available, affable and able.

**Available**

*"availability is the problem…because we are so busy…we need extra staff..."*

*"...sometimes it's holding their hands but other times it's just being there and actually affirming what they're doing, saying that's the right way."*

**Affable**

*"...interest and enthusiasm"*

*"... a pretty reasonable communicator"*

- A larger practice of affable supervisors makes supervision easier.

*"...having enough bodies in the practice is really useful, we're very lucky because we've got quite a few people and quite happy to be involved in the PGPPP or Registrar training and we're all approachable"*

**Able**

*"Somebody …interested in their [own clinical] work"*

*"Someone fairly diverse [in their own clinical practice]"*

*"Someone who is fairly up-to-date"*

## Other teaching issues

**Undergraduate**

- Locum GPs find it harder to predict which patients of the practice will tolerate student input in a consultation.
- Need to have time to spend with students to debrief after a session [3-4 hours of consulting].
- Forewarning practices about students who may be struggling for whatever reason (health or academic issues) was requested.
- Need to space out 3rd and 5th year medical students with preferably 2 weeks between them.
- Students need to prospectively and early in their term ask for an OSLER opportunity to avoid irritating their supervisor
- The clinical attachment forms are not seen as a useful means of giving feedback to academic staff about a student's progress when concerns are noted.
- A formal, confidential, known to all practices method for contacting academic staff about students of concern is needed.

*"the problem area is …the student [who] is really struggling…there needs to be an avenue that we are aware of to get feedback to you. Because the feedback forms that we discuss with the student...[will] always be tending towards the positive because we want the student to go away with a positive thought…"*

*"if we pick up that there's a significant issue…usually with their health for example depression…how can we confidentially get that through to you guys?…"*

- Students in their final year can assist the practice to a limited extent.
- Rural practices often take John Flynn scholars and Ramus students as well, who potentially remove a possible placement opportunity for UTAS undergraduates.
- Concern was expressed about the suitability of some students as John Flynn scholars due to e.g. immaturity and also to the arrangements for accommodation made for some of these scholars.
- Some GPs have developed resources for students to use.

*"I've just written scenarios for them [u/g]…And they will have to get through one of them every day… It's just something that we do every day so I've just got every day scenarios and have written them down and said I just want you to go through and see what you would do if somebody walked in with something like that."*

- Preference for final year students is based on their greater interest and skill in looking at management which forms more of the GP's routine work. Diagnosis and Examination is more of interest for 3rd years and this is less emphasised in GP unless acute problems are being dealt with.
- Third party practice administrative bodies like TasPrac Services need to be engaged to rally support for learners in practices at both medical and nursing student undergraduate level.

**Wave model (parallel consulting)**

- Room is needed for the Wave model to work.
- Choosing patients to see the student was seen as problematic.

*"…there are some certain critical patients that will come in and you know...are pretty much inappropriate for the student "*

- Taking medical student learners is a financial drain on the supervisor. Enthusiasm for teaching overcomes this but saturation point will one day be reached.

*"…money available to theoretically compensate you for not being actively seeing patients it's …woefully inadequate compared to what we actually earn…it softens the pain but actually it doesn't create…any kind of incentive. …I guess every practice has its sort of limit past where it can be generous and then after that we just have to say no we can't cope anymore. The only way you are going to shift that threshold up…is to pay basically exactly what we would have earned if we had been here crunching through all our patients, and that's going to be a number which the boffins aren't really going to want to pay."*

**PGPPP**

- PGPPP as a concept is not understood by many but many were interested to pursue having them in their practice.

*"I'd be very interested in those young doctors…"*

- Concern was expressed that the PGPPP program may be abused by sending inappropriate junior doctors into practice and not just for one term but a succession of terms.

*"….our recommendation in big letters everywhere was that she needed to go back to the hospital to get some basics before she went out and she spent the next year doing her PGPPP rotations so the..."*

- The limits on the earnings of the junior doctor are cumbersome and amount to too much red tape although GPs understand the need to protect these inexperienced doctors from being exploited.

*"….yet another compliance bog hole…".*

*"When we have most of them they end up on about three patients an hour which is very gentle and I think that's the sort of thing they should say perhaps no more than 15 minutely appointments or just have a rule like that rather than this money thing, it's just so silly"*

- Adequate supervision of PGPPPers needs to be scheduled into the day.

*" the debriefing process has been something that we have been experimenting with doing at different times and really haven't landed a fantastic solution to that...every case has to be looked over by the supervisor at the end of the day or at the beginning of the next day, or something like that, and it's just one of those things where it seems to take half an hour at least no matter how complicated or uncomplicated they are and of course it is a great opportunity to do some teaching along the way which all of us do so that drags it out a little bit further and it's not easy to fit that in …it gets back to…deliberately set aside…an hour's worth of patients at the beginning of the day and spend that going over yesterday's work but essentially we can't afford to really do that so what happens is it gets squeezed in at the end of the day or you come in early and squeeze in 30 minutes before your first patient arrives and then somebody rings up and wants to be fitted in and, you know, it can be a bit of a pressure to get that, that part of the role done."*

- Practices need a steady supply of PGPPPers but they must be of acceptable competence – interviewing the potential PGPPPers helps the practice determine this before they start.

*"Much easier for us to plan around having one every rotation but having …enough in the pool so that we could be really selective about which ones we take."*

- Having interns as PGPPPers was felt to be unwise.

*"…interns, you know I really don't think it's wise…"*

**Registrars**

- ACRRM associated supervisors have not participated in registrar training in the past as they have felt alienated from the RACGP.
- Continuity of supply of registered learners is important to deal with increased patient demand that tends to come from increasing workforce in a practice. Fluctuations are harder to cope with in solo or smaller group practices.
- Curriculum issue: Practice management and how to choose a practice to join are not covered adequately in vocational training.

*"…most of us have gotten thrown into practice management as well…And whether we like it or not you know, I initially wanted to join a practice but I didn't know what that was about but I couldn't join, I couldn't ask the questions without joining but I wanted to know before I joined but there's nothing. We're not taught that and that's a problem. I have spoken to GPTT about that as well."*

- Training to provide care in aged care facilities should be emphasised.

*"There's a view that, you know they say, I don't see nursing home patients and I mean I think that's not quite right. I mean if you do general practice you do the bits that are less glamorous or less well paid and more time consuming. I mean I worked out…because I've got so many and I've got house calls as well to do on a Wednesday that's all I do. I don't consult in the office here and I actually earn about half as much as if I worked a normal working day. That's perhaps part of the reason."*

- Increased contact with GPTT would be appreciated by both supervisors and at least one registrar. This is reflected in feelings of alienation from on-line learning initiatives.

*"They don't liaise"…"They like when they come to visit we rarely hear what they actually think or say"…"But they've got this thing called GP Rhyme now and I don't know what the uptake is?"…"I actually can't be bothered with it"…"Yeah and you're supposed to plonk everything onto it"…"I mean you have to because it's sort of your learning plan thing isn't it"…."Yeah, GP Prime, yep that's it."*

- On the ground assistance with problem learners would also be appreciated.

*"...they could actually come in, like if everyone's feeling something's difficult if someone comes in and has a look at it and tries something…we've had a few people in the past who've needed sort of remediation time and that's been a struggle sometimes"*

- Some GPs have specific interests that can add to the quality of the learner's experience. This may be more likely in a group practice.

*"…[with regard to registrar training] there is a lot of stuff that I don't see nowadays like paediatrics,…but then I start exploring with them when they come how does the contact you have with people affect you, so I go into specific areas that they probably don't get from others,…usually it's a bit more to do with them personally...like how they react to the heart sink patient…it's a bit about them and how to handle situations."*

**General**

- If I.T. was to be used to supervise from a distance it was expected that the learner's institution would pay for this.

## Awareness of the learner's needs before a learner starts at the practice assists practices

**Undergraduate**

- Students need to present their stated learning needs at the beginning of their placement so their learning plan is optimised.
- Having specific learning needs makes taking undergraduates easier e.g. diabetes care plans, particular skills such as doing an e.c.g. or an eye examination.

*"They come to us supposedly at a certain level and it's quite variable…what they do know"*

**Registrars**

- Non IMG basic term registrars seem pretty aware of what they should be getting out of the term and seem pretty skilled before starting.

*"some of the…IMGs that we have had on the training program are particularly coy about the areas they need up-skilling…"*

*"they say they have been in the equivalent of general practice and it takes a while to find out exactly what level they are at mixed in with cultural things and communication skills."*

**International medical graduates**

- Standardising the assessment of IMGs competence before presenting for work is needed.

*"...the IMGs, some of them show they've had all this experience and they get here and realise that they haven't a clue as well as not much English"*

### Use of registrars in training more junior learners

- Involving registrars in u/g or PGPPP learning and teaching will require planning and is unlikely to be successful if left to chance.
- Registrars may be able to relate better to more junior learners due to understanding the likely stage the learner is at and the learning institution the junior is attached to.

[registrar] *"I would teach [undergrads] if I needed to, I could offer what I know but I am more than happy to tell them from my perspective, from the level I'm at."*

*"The undergraduates in my experience, they do seem to like being with the Registrars…maybe the Registrars [more] than the older doctors because they just relate better and they often know a whole heap of the same people, you know they just slot in a lot easier, I think."*

*"I mean teaching is the best way to learn, isn't it?"*

### Evaluating competency levels

- Experienced GPs, who have learnt the breadth of their discipline, are ideally placed to evaluate the competency levels of various levels of learners

*"…a GP, we understand a breadth of stuff. Fair enough if you are new to the game you don't know that sort of breadth so we're probably a little bit more aware I suppose that it's a learning experience and it's a process, so a med student is not really going to know, is not going to have the clinical knowledge of a PGPPPer or a Registrar. I think we're better equipped with that than most other specialties"*

- Having more learners over time at a certain level allows honing of competency assessment via comparison to previous learners.

*"You certainly do compare, like we've got a med student at the moment and you compare what he's like to the last one"*

- A set of core competencies that a learner is meant to have achieved at the level of training they are at is often unknown by teachers (although available in written documentation).
- Clearer learning objectives might assist both u/g learners and GP supervisors avoid disappointing interactions between both.

*"…a set of core competencies that needed to be achieved by fourth year or needed to be achieved by fifth year or whatever and have access to those core competencies so there's a little bit more hard data to compare my intuition and experience against"*

- Communication about these competencies needs to be more than paper based, and/ or on one page only.

*"We don't want you to come around with this huge wad of paper"*

- The overarching professional attributes of a learner are usually easy for all to assess at the same level

*"…anybody can acquire knowledge, it's…more attitudinal…, the way people interact with patients, the way they process information…I think we've all got a pretty strong intuition about that and there's, you know, many times where we have all sort of agreed together that wow that student is top class or wow that person is struggling or something like that I mean we all know it, it's not hard…It seems to be about the art of medicine."*

- Some learners make a strong positive impact on patients as well as on their GP supervisors.

*"I've still got some patients wondering how (name withheld) is and what's he doing."*

**Sometimes teaching is not enjoyable if:**

- Learners who are not committed to or respectful of general practice are not appreciated and take the enjoyment out of teaching.

*" there are students I do not like that have no sensitivity to general practice, like the drongo last week who said 'she's only here for a script', that's like saying to the surgeon, you know 'here's a big fat belly, grab a knife mate'…'she's only here for her scripts' and I mean, they've got to be sensitised somehow that if you want to irritate the person you're with there's a couple of trigger lines, you know and that would be one of them.…And you gotta understand that patients are coming for a reason and if their doctor, their poor old doctor only thinks he writing scripts well he should be taken off the teaching because this person she had high blood pressure…and a past history of a stroke so this bloke you know wasn't processing and people who don't like rural practices, the drive inners and the drive outers, and those who, those who don't see general practice as a specialty and I mean they are hard work."*

- Students arriving late.

*"…they've got to be adult about their learning and understand what it is about, you know, what is primary care, general practice…it's a few per cent that give you ninety per cent of your problems, you know. I think those people need to be a bit more sensitised but maybe there's a few more who we should say mate, you know go back to town because you're obviously not happy here, speak to the boss and explain there your problem because you know it is just frustrating."*

## Clinical Supervision skills building

Provided by GPTT:

- The need to have repeated opportunities for skills building was noted because attendance at GPTT's workshops was limited to one supervisor per practice per meeting or the supervisor couldn't get to the meeting so missed the topic. Repeating the topics was felt to be good for those who missed a prior opportunity.
- The workshops are held in high regard "I think they are quite good" and provide appreciated networking opportunities "It's always nice to meet other supervisors and talk and things and get ideas"
- Flexible delivery options for skills building were called for:
    - 1 day workshops,
    - Expert teachers coming to the practice
    - on-line learning noting that the colleges may already offer activity here
    - Weekends 1 or 2 days
    - Evenings if efficiently delivered and, for some, less emphasis on the chit-chat, social networking
    - Lunchtime meetings to offer face to face feedback to the practice as a whole, or other CPD activities around skills building. These have to be planned well ahead to ensure time is freed up to attend

*"…having someone come to the practice for something like that would be better…."*

*"…crafting whatever the practice might need and having you together as a group, developing skills might be useful as opposed to one person going away…that would be good"*

*"…now [NPS pharmacist] comes down to me and speaks to me for at least a half an hour…now if I had an expert like that on different things that would be wonderful because I don't have any time off, I don't have time to go to town and do things."*

- Particular topics were requested as teachers perceived a need to stay up to date or ready for large change in how care is delivered. Clinical school computer labs used in conjunction with training provided by e.g. Divisions of General Practice could be a valued service to some of our clinical supervisors.

*"we're going to get IT stuff….videoing…IT enhancement, having the capacity to do other things with other practitioners in other places…I bumble along and learn as I go but no-one ever comes along and teaches me how to do it"*

- Some note sessional teaching at a clinical school assists in keeping up to date.

*"keeps me in the whole learning and education thing all the time and forces me to keep current so that's the reason, the big reason that I keep working because it just keeps me up-to-date which goes on to help my clinical work and then supervision"*

## Formal qualifications in skills building

- Interest in formal qualifications in supervision or medical education is only of interest if it will assist a practice in obtaining a medically registered learner (PGPPP or registrar).
- Some GPs feel that the qualification would just be a piece of paper.

"I've sat down and looked at doing that post grad teaching thing and thought I can't be bothered doing that, yeah I don't think it would made any difference other than given me a piece of paper."

- The concept of recognition of prior learning was raised.

"I suppose if you all got a piece of paper in recognition of prior learning then that would be nice"

- Perceptions of the structured or unstructured nature and associated assignments of formal qualifications act as disincentives.

"Some people do like the structure of courses…but not for me"

*"The problem with things like that is when you get to that post graduate level it's not necessarily structured and there's a lot of, probably, possibly useless assignments and that's why I was reluctant to do writing stuff that's just going to get me to a point without actually, you know..."*

- The list of learners a supervisor had taught was felt to be the best evidence of skill and ability.

*"One of my regrets that at the start of my career I didn't get the name of every medical student I've ever had, and every Registrar I ever had and the third thing I should have done was write down all the fascinating, you know amazing things that have happened and that would be the CV that would beat any other CV"*

## How do you obtain feedback on supervision and teaching skills?

**<u>Undergraduate</u>**

- Supervisors may seek feedback from each student face to face but note the limitations of this approach.

*"most of us learn best by getting feedback and that side of the loop is missing…I always try to make a point of asking them did you learn anything…tell me straight out now was this any use to you and so you get a little bit that way but off course…students…appreciate the*

*time you are giving them and they're not likely to tell you you're an idiot…so having some kind of feedback loop would be useful"*

- Vast majority welcomed the idea of collated student feedback

**GPTT registrars**

- Exit opinions from registrars are formally obtained via GPTT processes involving completion of forms but this is perceived not always to reach the supervisor. This might be because the feedback goes to one GP and co-supervisors might then 'miss out'.
- External clinical training visit reports can be a means of feedback if the visitor talks to the supervisor about that aspect of the Registrar's experience.
- An appeals system that allows negative feedback about a placement from a learner to be balanced by input from supervisors or the practice is requested. Some supervisors perceive bias in favour of the learner instead of the practice in this contested area.

*"if the Registrar writes…something about us that they don't like that becomes like the bible and …they believe every word of it and that's the only thing that we get..."*

*"We've had a couple of Registrars that have had serious mental illnesses and we weren't very well supported in looking after them. There are two sides to every story"*

- Visits to the practice by the director of the training program were thought to be essential for the program to understand firsthand the conditions learners are experiencing. Timely availability of the director of training to discuss issues supervisors might have was also thought to be vital.

*"…see their rooms have a poke around, realise it is much the same as last year and no-one else has moaned in the previous ten years so if you think your rooms a bit small well there might be something going on, there might be some other issue and you've got your antenna up, but there's none of it [checking out veracity of complaints]"*

- Supervisors have changed practice based on registrar feedback.
- "[they were] given too much work to do straight away…so they were given a lot more time to settle in rather than getting straight to work"

## GP as consultant and teacher

- Interest is strong from many GPs.

*"Exactly. I would like that. You see [we] are pulling back and this would be just the perfect sort of way to do it."*

*"Yes, absolutely [interested in this role]"*

- Just how much such a GP would expect to be paid to do the job is unknown.

- GPs acknowledged the need to change to this sort of role to encourage more postgraduate medical learners into the practice.
- The role could be shared across senior GPs to encourage sharing of the benefits and pitfalls and to ensure coverage for the whole year.
- Introducing such a role will require the use of change management principles.
- The need for more fulltime GPs who are not learners to enable such a plan was noted.
- Registrars in their advanced or subsequent terms might assist the plan.
- Experienced clinicians were needed for the role.

*"it's for an experienced clinician…instead of doing what we're doing at the moment where we're actually seeing a full case load…it means you've got a whole session…where you're going to be supervising"*

- Such a role may help avoid burnout in teachers.

*"I think the idea of having a different model would be really nice, say okay this morning I had to see three people, that's what I had to do, I had to look after the med student, the PGPPPer, the Registrar it takes the pressure right off but as long…you will be getting paid the same as if you worked your back side off all morning but you don't have to do that you're doing something different. That would, I think it would be more sustainable because I'm a bit worried if we have more med students and somebody's going to say (throwing arms in air) 'oh, I'm knackered'..."*

- Various models were put forward.

*"the ideal models would be, besides having pure clinical sessions, a lot of…sessions would be supervising the Registrars and doing teaching components where newer people coming into the practice…would hopefully be younger and want to be working hard earning incomes very big for them, whereas…it's important to me…[to have] the lifestyle thing of having more people in the practice and sharing the load…so you're just doing second on calls to a lot of these juniors..."*

- Some noted that doing such a role full-time may not appeal and may be costly.

*"If the principle doctor sits out from his/her earning capacity and just supervises well they would probably go bloody stupid in just about a day but they're going to need at least $1000 a session"*

### Learner's perspective

- The steep learning curve of starting work in general practice should not be under estimated

[registrar comment]*"…I think it is a difficult area to start off in…I'm still adapting, I mean what, nearly three months…I thought internship was pretty steep but now...minimal, minimal [support from the training program]"*

- Feedback gathered from registrars in visits to the practice is recommended]

[registrar comment]*"…just talking to people, I think you get a lot more out of hearing what they have to say rather than being confined to …writing down, you're a lot more open and less formal about how you're really feeling, registrar or student, because will give you a lot more information than they'll write."*

### Nursing – undergraduate learners & other

- Coordination of nursing placements via a central practice person is recommended – usually the practice manager.
- Agitation for practice incentive payment for the practice to take nursing students is needed.
- Nurse practitioners are learners requiring GP supervision as there are too few NPs to supervise others at this stage.
- GP Nurse Practitioner supervisors have been concerned that their supervision role is indistinct and their options of response to poor NP practice have been unclear.
- Ways to assist practices to take nursing students in a manner less likely to slow service provision are needed.

*"oh we've limited them because they are a lot of hard work" "and there's no financial remuneration" "we don't actually have any control over them, they come in here, well we do now but one of the nurses who's leaving our employ would organise them and they would just turn up"*

- Medical students learn about nursing roles and other aspects of care delivery within and outside the practice by spending time with the nurses.

*"…involve them [medical students] with the nurses, they spend some time with the nurses and also with the community child health nurse..."*

- Postgraduate nursing up skilling in rural and remote nursing seems to be an unmet need.

*"…we have a lot of nursing students, we have a lot of graduate nurses who are as keen as mustard to learn whatever we can teach them, which we do. The first thing they learn is cannulation etc. but if I have something new that I am doing they're the first ones there willing to learn and wanting to learn and it's a vacuum that's not being filled."*

## Enablers and Barriers for GP MAGIC summarised

**Undergraduate**

| Enablers | Barriers |
|---|---|
| Enthusiastic learners & teachers | Service provision interruption and drop in income of GP |
| Clarity from UTAS about expected learning outcomes | Space for learner |
| Capacity is available if supported | Student attitude & behaviours- rural, GP |
| Feedback from UTAS | Slowing of service delivery |
| More senior students to be most heavily engaged in consultations. More junior learners less so. | Part of the total burden of supervision |
| Reflective time with student | Clear processes for learners in difficulty |
| Skills building | |

**PGPPP**

| Enablers | Barriers |
|---|---|
| Interview process first | Space for learner |
| Support from organisations who send them | Concern about competency of learner (global & specific) |
| Many practices are keen | Not enough placements |
| Skills building | Service provision interruption and drop in income of GP |

**Registrars**

| Enablers | Barriers |
|---|---|
| PGPPP – gives learner a taste before committing to V.T. though not the only reason to undertake PGPPP term | Partner and their career/job |
| Practice wide approach to supervision and teaching | Concern about competency of learner (global & specific) |
| Passion to teach on supervising GPs' part | Enough interest from junior doctors |
| Support from learning organisation | Service provision interruption and drop in income of GP |

**IMGs**

| Enablers | Barriers |
|---|---|
| Willingness to commit to a practice for a long time | Concern about competency of learner (global & specific). |

**Nurses**

| Enablers | Barriers |
|---|---|
| Awareness of requests from SNM to take undergraduate nurses at practice manager and owner GP level | Increase total practice burden of supervision |
| More information about postgraduate nursing requirements and encouragement of whole of practice approach to supporting learners | Poor communication from training organisations about requirements |

**Key Issues and Future Directions - all are linked.**

**Supervision & Teaching Skills Quality improvement**

- Shared curriculum
- Flexible approach
- Recognition of prior learning

**Community of Practice**

- Shared approach to supervision & teaching
- Skills building of the practice team
- Digital habitat

**Quality of General Practice**

- Consultant teacher as leader
- Teaching as a way of staying up-to-date
- Team care enhanced

**The Feedback Loop**

- Capability of learner and teacher – closing the loop
- Feedback about institutions
- "Learner at risk"

**Time**

- Models (e.g. WAVE)
- Review what undergraduate students do in practices

**Inter Prof Practice**

- UTAS P.N. and N.P. training
- Future models of GP team based care
- U/G nursing

**Infrastructure**

- Room/Space
- Connectivity

**$$$**

- Loss of income for practices compensation
- Sustainability

**Patient Care**

- Patient as partner in teaching
- Learners contribute to health outcomes

**Engagement with School of Nursing and Midwifery**

During 2010 Jan Radford approached Denise Fassett, Head of the SNM, to progress the issue of post graduate training for Practice Nurses (PNs) in Tasmania. Some university units had been made available to Tasmanian PNs in the past decade by General Practice Tasmania as a Federal Government initiative using a Queensland university as source.

Meetings ensued between the SNM and General Practice Tasmania to devise a way forward. As of now the plan is to offer the first unit in a graduate diploma course in semester 1, 2012.

The appointment of general practice Nurse Practitioners who can lead this is imminent. Jan Radford and other GPs associated with GP MAGIC plan to assist in writing one unit which will be pitched as an introduction to the systems within general practice and ideally completed by both a PN and a GP together. It will be designed so that GP registrars would gain greatly from this.

The first 4 units to be used, otherwise, will be adapted from other postgraduate nursing courses for ease of starting this offering. Over time refinement of graduate diploma and evolution of graduate certificate and masters level units is envisaged. The recent development of NP studies by UTAS's SNM across all levels of post-graduate nurse specialisation will be relevant to Tasmanian PNs too. Currently there are 3 NPs in Tasmanian general practice at various stages of readiness to prescribe as the legal framework is finalised. These NPs have obtained their qualifications from mainland universities. At this stage 2 of these NPs are likely to lead the development of the PN course development at UTAS's SNM.

Assoc. Prof. Sheryl Brennan of the School of Nursing and Midwifery's postgraduate studies area leads this work.

**Prospective Longitudinal Study of Medical Undergraduate Attitudes to General Practice and Rural Practice.**

This started with the year 2 cohort of MBBS students in 2008. Surveys were undertaken then, poorly responded to surveys were repeated in 2010. The plan is to systematically survey the group in 2011 and to carry out focus groups in all 3 regions. Lack of Funding has been a problem to date to carry out this work. This is an ethics approved study from the UTAS Social Sciences Human Research Ethics Committee Reference No. : H0009722 titled "Rural and General Practice – a prospective Research Study." Little useful information has yet been obtained.

## References


AIHW. (2006). Australia's Health 2006 (Vol. cat.no.AUS73, pp. 1-528). Canberra: Australian Institute of Health and Welfare.

AIHW. (2008). Australia's health 2008. Canberra: Australian Institute of Health and Welfare.

AMWAC. (2005). Career decision making by post graduate doctors, key findings. Sydney: Australian Medical Workforce Advisory Committee 2005.3.

Boerma, W., & Dubois, C. (2006). Mapping primary care across Europe. In R. Saltman, A. Rico & W. Boerma (Eds.), *Primary care in the driver's seat? Organisational reform in European primary care* (pp. 22-49): Open University Press.

Britt H, M. G., Charles J, Pan Y, Valenti L, Henderson J, Bayram C, O'Halloran J, Knox S. (2007). *General practice activity in Australia 2005-06.* Canberra: Australian Institute of Health and Welfare.

Calder, R. (2007). *Medical Training Review Panel 11th Report* (No. 11). Canberra: Commonwealth of Australia.

De Maeseneer, J., Willems, S., De Sutter, A., Van de Geuchete, I., & Billings, M. (2007). Primary health care as a strategy for achieving equitable care: WHO.

General Practice Tasmania. (2010). *Census of Tasmanian General Practices October 2010*. Hobart.

Harris, M., & Harris, E. (2006). Facing the challenge: general practice in 2020. *Medical Journal of Australia, 185*(2), 122-124.

Harris, M., Proudfoot, J., Jayasinghe, U., Holton, C., Powell Davies, G., Amoroso, C., et al. (2007). Job satisfaction of staff and the team environment in Australian general practice. *Medical Journal of Australia, 186*(11), 570-573.

Joyce, C., & McNeil, J. (2006). Fewer medical graduates are choosing general practice: a comparison of four cohorts, 1980-1995. *Medical Journal of Australia, 185*(2), 102-104.

Joyce, C., McNeil, J., & Stoelwinder, J. (2006). More doctors, but not enough: Australian medical workforce supply 2001-2012. *Medical Journal of Australia, 184*(9), 441-446.

OECD. (2007). OECD Health Data 2007. Paris: Organisation for Economic Co-operation and Development.

Roxon, N. (2008). General Practitioner Registrar number increase. Launceston.

Royal Australian College of General Practitioners. (2007). GPs and General Practice Teams. Retrieved 15th February 2009, from http://www.racgp.org.au/policy/GPs_and_their_teams.pdf

Scott, I., Wright, B., & Brenneis, F. (2004). Career choice of new medical students at three Canadian universities: family medicine versus specialty medicine. *Canadian Medical Association Journal, 170*(13), 1920-1924.

Starfield, B. (1998). *Primary Care: Balancing Health Needs, Services, and Technology*. New York: Oxford University Press.