Corridor teaching

'Have you got a minute...?'

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Australia uses the 'enhanced apprenticeship' model of general practice training, whereby vocational trainees are placed in everyday general practices in a supported environment. While trainees have regular scheduled teaching sessions and release programs, an integral part of their learning is the casual, 'corridor' contacts during their consulting sessions. The North East Country Region of the RACGP's Training Program sought to examine what went on in those contacts.

General practice training in Australia has as its cornerstone the 'enhanced apprenticeship' model, whereby vocational trainees (registrars) are placed in standard general practices throughout the country. Within those practices registrars have a designated supervisor, but can receive teaching from any general practitioner in the practice. Direct teaching comes from three sources:

- release programs where registrars are released from the practice to participate in small group learning with educators
- dedicated teaching time allocated during their time in the practice, and
- ad-hoc teaching.

This ad-hoc teaching usually occurs in response to a specific problem – a patient with a condition the registrar doesn't recognise or doesn't know how to treat. The response needs to be timely and appropriate.

The Australian General Practice Training Program recognises that registrars are adult learners, in that they have prior life experiences and are motivated to learn by those experiences and their own need to be self directed, with learning driven by their situation.[1]

Constructivist learning theory holds that learners create their own 'constructs' based on what is presented to them.[2] Teaching in practice is the classic context for this to occur – for registrars have an immediate learning need that occurs in the course of a consultation.

In 2000, during a routine supervisor development workshop, the supervisors of the North East Country region of the Victorian arm of the Royal Australian College of General Practitioners (RACGP) Training Program looked at the issues surrounding 'corridor teaching'. The perception among the group was that this was an important area of learning that was under appreciated by policy setters. The cumulative experience of the group was that these were usually short contacts, initiated by the registrars, and usually related to presenting problems. The group tried to develop some guidelines for teaching in this scenario but felt the need for data on the content. An analysis of the literature revealed little on what is a core learning activity in vocational training. Irby[3] proposed that effective clinical teachers were enthusiastic, clinically competent, organised and accessible. Neher et al[4] proposed a five step process of teaching family practice residents in a clinical setting, based on the principle of:

- get a commitment
- probe for supporting evidence
- teach general rules
- reinforce what was done right, and
- correct mistakes.

Heidenreich et al[5] attempted to assess the effectiveness of ambulatory teaching methods (after dividing them into 12 categories) but was unable to identify specific evidence of effectiveness. We were not able to identify any studies looking at specific content, which it was assumed represented the full spectrum of primary care presentations. None of the literature seemed to address the specific needs of the corridor teaching experience.

Methods

The setting was a rural teaching region in northeast Victoria, reaching from Shepparton in the west to the Snowy Mountains, and from Albury Wodonga in

Table 1. Teaching contacts

	Number of contacts (per week)	Total time spent (minutes)	Time per contact (minutes)
Mean	8.7	37	4.7
Median	8	39	3
Low range	3	7	1
High range	33	70	45

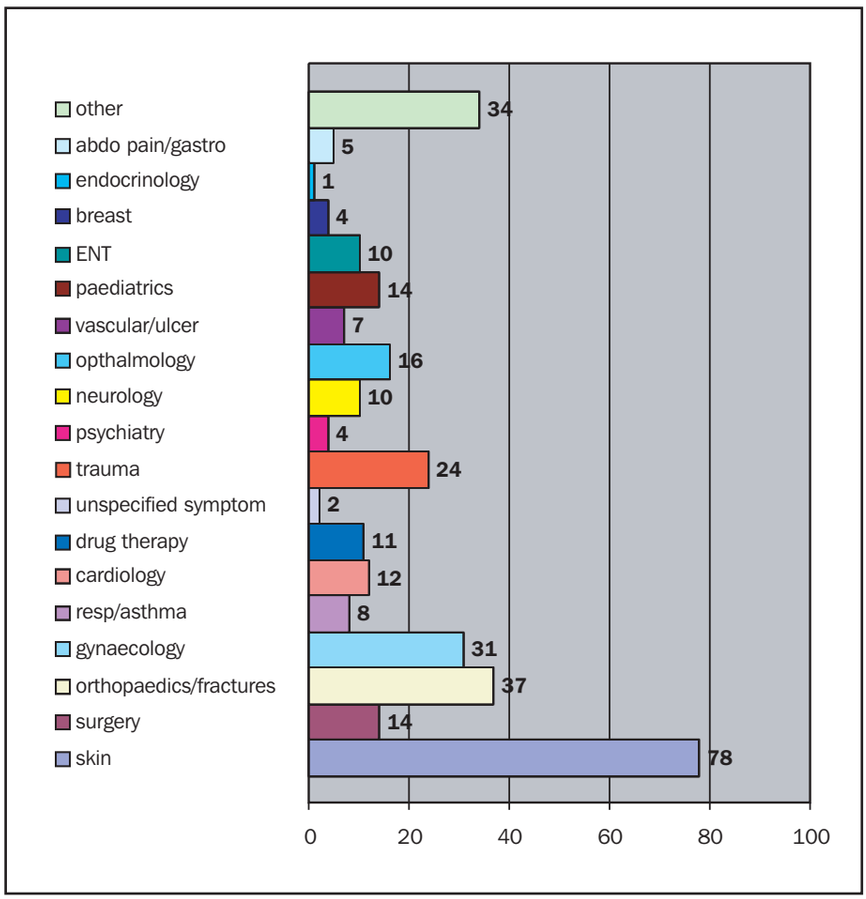

Figure 1. Clinical content topics

the north to Seymour, 75 km north of Melbourne.

During one of their professional development workshops, the supervisor group decided to pursue a prospective audit with the registrars in their practices. It was felt that the registrars provided the common point of contact, so they would fill out the audit, rather than the various supervisors they may encounter in the practice. The key fields developed were:

- date/time of contact
- duration
- points covered, and
- points learnt.

Four weeks were chosen during a six month term, usually the first week of the month, excepting the first two months while the registrar familiarised themselves with the practice. The diary was trialled with several registrars during the last weeks of a term, and then implemented during the next term.

Numerical data was collated and analysed using descriptive statistics. The diaries were analysed by the author and the topics covered were broken up into the five domains of general practice, according to the RACGP Training Curriculum.[6] They were then further subdivided according to the nature of the inquiry. Codings were based on the predominant theme of the 'points learnt' section of the diary.

Results

Twelve practices agreed to participate giving 11 possible registrars. Registrars were in both basic (first GP term) and advanced (second GP term). One practice was unfilled. Of 44 possible weeks, we received 41 completed diaries (a response rate of 93%). From the diaries we were able to generate 328 contacts for analysis, either fully or partially (*Table 1*). The small numbers of registrars precluded comparisons on the basis of age/gender/cultural background. Eighty-four percent of contacts were recorded as being of five minutes or less duration.

Problem classification

Each contact was classified according to the most appropriate domain of the RACGP curriculum[6] covered by the presented problem. The vast majority of problems were primarily related to the 'applied professional knowledge and skills' domain (295 or 90%). Twenty consultations (6%) related to the 'organisational and legal issues' domain and mostly related to two distinct classes of problem – either an issue with prescribing (usually S8 drugs of dependence) or appropriate referral agencies for mental health problems. The other three domains generated only one or two consultations each.

Given the large number of contacts in the 'applied professional knowledge and skills' domain, they were further subdivided into whether the primary question was about diagnosis (50%), treatment (40%), or

how to perform a procedure 10%).

In addition, the clinical skills section was analysed according to topics covered. Skin conditions were by far the most common source of contact, accounting for 26% of contacts, followed by orthopaedics/fractures (12%), gynaecology (10%), and trauma (8%). Together these four categories comprised 50% of the contacts (*Figure 1*).

Discussion

We undertook this study following a discussion on ad-hoc teaching in general practice. Our experience was that the problems presented were clinically related, and that they presented opportunities for teachable moments. However, we found that this significant area of teaching has not to date been examined in any systematic way. The findings do, however, reinforce the perception that this form of teaching represents significant numbers of brief, registrar driven contacts that revolve around a specific subset of problems.

Although any patient contact can generate a corridor teaching moment, skin problems, orthopaedics and fractures, gynaecology and trauma are disproportionately represented. There may be a number of reasons for this. Dermatology, trauma and orthopaedics are heavily reliant on 'pattern recognition' rather than any hypothetico-deductive model of diagnosis. This may well make them better suited to this short form of teaching. The same could not be said of gynaecology, however. Another explanation is that this list may reflect shortcomings in the registrars' undergraduate exposure to these problems. It may also reflect that, in the registrars' minds, these conditions are more likely to produce problems that require an immediate answer – deferring the problem until another time is not acceptable. In the context of fractures, this may be due to clinical need; in the case of dermatology, registrars may feel this an ideal opportunity to have the problem dealt with immediately when the supervisor is able to inspect the patient's problem.

This is a brief, descriptive study and its methodology is not robust. In particular, the nature of the audit (self reported by registrars) may lead to significant errors in reporting. There was a sense among the group of supervisors (when reviewing the results) that there was significant under reporting of the number of contacts. Thus, the figure of 37 minutes per week is likely to be higher, although this could only be demonstrated by having the supervisors keep their own diary for comparison. Nonetheless, even if we take the figure of 37 minutes, this represents a significant amount of time in a busy practice, especially when there are other time demands for teaching during the week.

This presumed under reporting is unlikely to have affected the figures for length of contact, or changed the results for the topics raised. Given the source of the problems – patients presenting with specific complaints – it is not surprising that clinical problems comprised the lion's share. They were fairly evenly split between either a diagnostic or a treatment problem with a small number of requests to be shown a specific procedure.

The amount of supervisors' time consumed by brief, ad-hoc teaching contacts can be quite significant, albeit in frequent, small amounts. We also now have an idea of the types of problems encountered and the needs of the registrars. It is, however, only the beginning. There needs to be a better analysis of numbers of contacts and the total time consumed for the information of planners of teaching. There also needs to be closer analysis of the objectives of the contacts to design a teaching process that better meets the needs of the learners. Do corridor consultations between registrar and supervisor result in learning or just being given the answer?

Ideally a larger study would also be able to examine in detail issues such as geographic location, gender, length of time in the program, cultural background and other important factors that we were not able to address. In the meantime, we have some evidence that teaching during corridor consultations is an important and integral part of general practice training.

Acknowledgment

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