

Contents

Training standards, roles and responsibilities	2
Overview of the role of a general practice trainer	2
Preparing to be a general practice trainer (including information for practice manager/reception staff)	3
Overview of the role of a regional training provider	6
Welcoming the registrar and introducing them to the practice	6
Reducing risk	8
Curriculum	9
Curriculum for general practice training	9
The curriculum framework	10
Practice based teaching	13
Characteristics of adult learners	13
Self directed learning	13
Learning styles	0
Learning styles case studies	0
Learning styles questionnaire	0
Planning teaching and learning in a general practice	0
Identifying learning needs	0
Reflection	0
Negotiating learning goals	0
Formulating a learning plan	0
Structured teaching time	0
Teaching and learning methods	0
Deciding what method to use	0
Commonly used teaching and learning methods in a general practice	0
Direct observation of consultations	0
Constructive feedback	0
Models of feedback	0
Learning profiles/portfolios	0
Topic tutorials	0
Case discussions	0
Practice audits	0
Demonstrations	0
Role plays and simulations	0
Resources and framework	0
Suggested practice library	0
Helping your registrar prepare for the RACGP examination	0

■ Training standards, roles and responsibilities

Congratulations on becoming a trainer for the next generation of general practitioners. General practice trainers play a crucial role in ensuring the future health care of our country, and the discipline of general practice.

Your college, the Royal Australian College of General Practitioners, has set high standards for its trainers in order to ensure the quality of training of our general practice registrars. You have met those standards with regard to the clinical care you offer your patients, and have undertaken to support and teach general practice registrars in their practice.

This manual has been prepared to assist you in your training role. It is based on manuals prepared by the RACGP training program.

Overview of the role of a general practice trainer

A general practice trainer (supervisor/mentor) is a doctor whose practice has been accredited by the RACGP to train general practice registrars. The general practice trainer's role is to supervise and teach the general practice registrar while working as a GP.

The general practice trainer is of central significance in the training of our future GPs. The general practice term is the most important part of general practice training. Virtually all general practice registrars report the experience is very valuable to them, and it is usually during this time that registrars become highly enthusiastic about general practice and amplify their focus on it.

The role of the general practice trainer is therefore crucial to the whole training program. While the most important learning experience for registrars is simply being in general practice and doing the job, this can be enriched considerably by the supervisor's input. Many general practice registrars would like more input from the trainer – they place a high value on closer contact, feedback on their performance, and teaching time. General practice registrars' most common criticism of the training experience is that they do not spend enough time with their trainers, and need more constructive feedback and teaching.

Specific tasks of the general practice trainer

- to provide orientation to the practice as outlined in *The RACGP standards for trainers and training posts* (standard T.19)
- to ensure the registrar has adequate insurance cover and is registered with the state or territory medical council for clinical work to be undertaken (standard T.20)
- to schedule at least 1 hour of protected contiguous time per week for face to face teaching and discussion with the registrar for all general practice attachments, and to provide a planned education session during this time (standards T.6 and T.16)
- in a registrar's first 6 months in general practice, the trainer must be available for teaching, support and discussion for 3 hours per week; reducing to 2 hours in the following 6 months, and then to 1 hour in the next 6 months. This is inclusive of the 1 hour face to face for all registrars (standard T.9)
- to assist the registrar in the development of a learning plan, to be completed by the fourth week of each 6 month training period (standard T.14)
- to be on site with the registrar while they are seeing patients at least 80% of the time in the registrar's first 6 months of general practice; reducing to 50% in the next 6 months, and then to 25% in the next 6 months (standard T.22)
- when off site, to ensure they are contactable by phone or have made arrangements for another recognised general practice teacher to be available. This includes after hours (standard T.24)
- to be available at all other times the registrar is working, if assistance is required
- to support access for a medical educator to undertake direct observation sessions as prescribed by the general practice training provider

- to assess the registrar's competence in areas that have an increased risk of adverse outcomes and litigation – see list in *The RACGP standards for trainers and training posts* (standard T.17)
- to provide feedback to the general practice registrar regarding their clinical work (see *The RACGP standards for trainers and training posts* page 5)
- to participate in continuing professional development aimed at improving their own performance as a general practice educator (standard T.5).

Preparing to be a general practice trainer

When considering becoming a general practice trainer, the most important question to ask yourself is why you want to take on the role. Registrars are not locums; they are not cheaper than an assistant; and you may have little choice in which registrar ends up working with you. If your motivation is to find another GP for your practice, you may be disappointed.

On the other hand, if you are in need of a challenge, value the stimulation of having a new young GP question you about your clinical work, and would enjoy teaching and talking about patient problems, you are likely to thoroughly enjoy the role of general practice trainer.

What do you need to provide for a registrar?

- **patients**

Junior registrars ideally see between 80 and 120 patients per week. Each junior registrar will typically be with you for only 6 months, so will be unlikely to build up their own following in that time. Ask yourself whether you have a sufficient patient load for a registrar, bearing in mind you will need to allocate some of your time for teaching and supervision and will therefore not be able to see as many patients as usual. There are some registrars training part time – if you prefer a part time registrar, discuss this with your training provider

- **a room and equipment**

It is best if the registrar has their own room. Having to move between rooms is very disruptive and makes them feel devalued. If moving rooms is a necessity, make sure there is a trolley containing their own papers and equipment that can be easily moved with them

- **practice library**

Registrars are with you to learn, and require appropriate reference material. See standard T.31 in *The RACGP standards for trainers and training posts* for a suggested list of such materials. They may be provided in electronic form

- **appropriate working hours and conditions**

Registrars need time off to attend group education events. Check with your training provider about local arrangements and ensure you can meet them. Also check the current national minimum terms and conditions which were agreed between General Practice Registrars Australia (GPRA) and the National General Practice Supervisors' Association (NGPSA), with the assistance of the Australian Medical Association (AMA). Make sure you can meet these and be prepared to discuss them with your registrar

- **time to supervise and teach**

Check the requirements for teaching and supervision at different stages of training in *The RACGP standards for trainers and training posts* and ensure you can meet them. Taking a registrar will necessitate decreasing your own patient contact hours in order to spend time with the registrar. You will need to set aside uninterrupted time for teaching. Talk to your colleagues about how involved with teaching they will be, and how you will share these tasks

- **teaching skills**

Your regional training provider and the RACGP run training sessions for general practice trainers. Contact either organisation to find out when these occur, discuss any other issues you might have, or obtain support that may be available to you.

Preparing your practice

Once you have made the decision to have a general practice registrar in your practice, how do you make the next 6 months or more an effective learning and working environment?

Develop a practice profile. This should include:

- demographics of practice patients
- names and special interests of practice or doctors
- names of staff and their respective roles
- equipment and where it is located
- involvement in 'extended' practice – local hospital, nursing homes, divisions
- appointment system/patient numbers for registrar's patients
- details of local specialists, xray, pathology and other necessary contacts
- local services in allied health.

Ensure that other doctors and staff understand:

- the registrar is a fully qualified doctor, but is just starting in general practice and is at your practice to learn and gain professional experience
- the requirements of the RACGP and regional training provider, regarding the number of patients to book per hour and allowing for teaching time
- that teaching time between you is an important requirement and not to be routinely interrupted.

When you are allocated a registrar, contact them and try to set up a meeting.

With the registrar, discuss:

- a brief background of your practice
- their expectations and learning needs
- the things they must organise, eg. provider number, prescriber number, medical defence, banking/superannuation fund details
- tools of the trade they will be expected to provide, eg. stethoscope, ophthalmoscope and doctor's bag
- terms and conditions (see www.racgp.org.au/trainingstandards). It is recommended that you both sign an employment agreement. Registrars must be employed, not contracted.
- finding a time to show them around the practice and introduce them to staff.

Organise the fundamentals for the registrar:

- PBS and authority scripts, doctor's practice stamp, doctor's personalised pathology forms and other documentation needs
- for rural practices, accommodation requirements according to terms and conditions.

Information for practice manager/reception staff

What can I/we do to prepare for the general practice registrar?

Your role is vital in helping to prepare for the new general practice registrar so they have a worthwhile educational and working experience. Helping the registrar to fit in at the practice environment will also help the practice to continue to run smoothly and efficiently.

What is a general practice registrar and what will they do here?

General practice registrars are fully qualified doctors who are specialising in general practice. These doctors have undertaken a commitment to further training to help them prepare for the challenges of general practice. They spend at least 3 years undertaking further training after their intern hospital year – 1 year in hospital training and the remainder in general practice.

As you are aware, there is now a vocational register for general practice that entitles patients of these doctors to higher Medicare rebates for consultations. General practice registrars who are doing further training in your practice are eligible to claim vocational registration rates while they are doing accredited training time. The doctors in your practice pay the salary of the general practice registrars but receive a subsidy towards that salary. A teaching allowance is also paid to compensate for the time spent in teaching.

What is expected of teaching practices?

Teaching practices are accredited to provide training for doctors entering general practice. The doctors in your practice have undertaken to provide supervision of general practice registrars enrolled in the training program, and to teach them about general practice. The practice is expected to be able to provide a suitable number of patients for the general practice registrars.

Depending on the registrar's level of training, the supervisor is expected to provide 1–3 hours of teaching per week. This may occur in a number of ways – discussing medical topics, joint consulting sessions, or videotaping some consultations for learning purposes.

This teaching time is dedicated teaching time. Check with the supervising doctor(s) in your practice as to when and where these teaching sessions will take place each week so you can make sure patients are not booked at this time, minimising interruptions.

Who else is involved in teaching/training?

You will also have visits from a medical educator from the training program. This person, who in most instances is a practising GP as well as a member of the educational staff of the RTP, is there to assist in supervision and teaching of the general practice registrar and provide feedback to the registrars on their consultation skills. The medical educator will talk to the doctors in your practice, sit in with some of the consultations, or watch videotaped consultations with the general practice registrar.

All of this can only occur with the cooperation of patients. Your assistance is sought in explaining all this to the patients.

Vocational training

Experiential learning (learning by doing and/or observing) is a key feature of the training program. Doctors in training are relatively inexperienced in general practice so they will need to spend more time with their patients, and also more time between patients to reflect on what they have learned. The general practice registrar will also need time to discuss issues with their supervisor and other doctors in the practice.

General practice registrars also spend some time out of the practice to attend courses at the RTP training program, and they are expected to undertake projects while working in your practice.

You can make a valuable contribution to their training by teaching them about practice management details such as accessing medical records, billing systems and training in practice computer systems.

How can practice manager/reception staff help?

- help general practice registrars learn about general practice, particularly how the practice runs and aspects of practice management (such as accessing medical records, the practice billing system, and issuing certificates)
- book a suitable number of patients for the general practice registrar. Encourage patients to see the new doctor and explain to patients that the general practice registrar is undertaking further post graduate training in general practice. Discuss with the doctors in the practice how many patients you should book for the registrar each hour – the usual guidelines are two to three patients per hour in the first 3 months of general practice terms, three to four patients per hour in the following 3 months, and then four patients per hour for the remainder of their general practice terms. Registrars should not be booked more than four patients per hour
- when there is another doctor sitting in with the general practice registrar, or when consultations are being videotaped, explain the role of the general practice registrar to patients (after discussion with the doctors in the practice)
- protect teaching time and ensure teaching of the general practice registrar takes place. It is all too easy for teaching time to be cancelled due to extra consultations or home visits. Ask the supervisors when they plan to teach, and mark that in the appointments book. Keep teaching times free from unnecessary interruptions.

You can contribute greatly to how much the general practice registrars gain from their time with the practice. Your help is much appreciated.

Overview of the role of the regional training provider

Under the current arrangements, GPET (General Practice Education and Training) administers training for general practice in Australia, according to RACGP standards. The training is provided by 22 regional training providers (RTPs) across Australia, with GPET funding.

Each RTP employs a part time supervisor liaison officer (SLO), who is a general practice trainer themselves. That person's role is to liaise with other general practice trainers in the region. In addition, the NGPSA can advocate on behalf of general practice trainers. The SLOs have an active role in that organisation.

Trainers and training posts are accredited by the RACGP, but the local RTP chooses the training posts it will use, and places registrars in them. The RTP is accredited by the RACGP to deliver training in the region. This includes the provision of educational resources, support for registrars and for trainers, and face to face group and individual teaching. General practitioners wishing to be general practice trainers must approach their local RTP.

The RACGP also has a role in supporting GPs who are training its future members. This manual is one way in which this is done; running training workshops is another. All trainers should stay in close contact with their RTP and fulfil local requirements. Continuing contact with the RACGP is encouraged, and if there are local problems, trainers are encouraged to contact their RACGP state faculty for assistance.

For more information see the list of RACGP faculty contacts at the back of this manual.

Welcoming the registrar and introducing them to the practice

A general practice registrar's first day in the practice is typically a Monday. The difficulties this presents to practice staff are obvious. How can you cope with a busy Monday morning and spend time introducing the general practice registrar? However, the general practice registrar does need to feel welcomed and not left to get on as best he or she can, with no one available to answer the hundreds of little questions that crop up. Some of these questions can be dealt with if the general practice registrar visits the practice prior to commencing the term, but many others arise that he or she will have been unable to anticipate.

The input you have in the first few weeks of the registrar's orientation to your practice is crucial in their development into a safe, productive, learning member of your practice and profession. It can make a huge difference to a registrar's early adjustment to know their supervisor 'cared'. Comments reported include: 'He invited me for dinner with his family ... She made sure the flat was warm when I arrived and left me a note ... He introduced me to everyone in the practice and discussed my role and their roles ... She asked me what I wanted to get out of the term ... He never seemed too busy to help me'. Unfortunately feedback from some registrars has reflected a different approach: 'I was booked in from the first morning ... The receptionist staff would not show me how to find information on the computer ... I was never invited to the doctors' meetings ... I didn't know I should charge for a pregnancy test'.

General practice registrars who have no previous experience of general practice have a lot to digest before they can become useful members of the practice. They need to be told about:

- records – how to record all relevant information in an easily retrievable fashion without writing out a full history and examination
- prescriptions – the various forms, allowable items and costs
- referrals – who to use, what to include in a letter
- house calls/doctor's bag – what to take, how to assess someone at home
- government forms – worker's compensation, nursing home admissions
- billing – the importance of accuracy, cost of items of service, Medicare forms.

Some of these topics may be covered during the educational release program. However, further questions inevitably arise. No matter how experienced the general practice registrar is, he or she will also need specific information about your practice. Preparing a practice manual with relevant details about your practice will assist general practice registrars to assimilate this information.

Suggestions for orientating a new registrar to your practice

These are some options you may wish to consider:

- schedule time off to orientate the registrar
- involve the practice manager in welcoming the new registrar
- do not book any patients for the first morning
- check in with the registrar regularly to see if problems have come up
- have a name tag for the door of their consulting room – this will give a clear message that they are expected
- arrange for the registrar to sit in with you for the first session.

Recommended procedure upon arrival of the registrar

Walk them around the practice

- introduce the registrar to the receptionist, other doctors, practice manager and other staff. Explain each of their roles
- show the registrar the layout of the practice including reference books, procedure room, drug cupboard, emergency equipment, and where things are stored
- explain the filing, appointment and billing system
- explain how to access assistance during a consultation/while on call.

Sit in their room with them

- ensure there is a fully equipped consulting room for the registrar
- review the set up of the room
- review the resources within the room
- orientation to computer and software used in the practice.

Review the terms and conditions

- ensure the registrar understands them
- ensure both parties sign the employment agreement
- review the practice roster, including after hours/on call arrangements
- discuss other issues such as practice philosophy, dress code, who to contact in case of personal illness, flexibility with appointments and after hours philosophy.

Recommended procedures for the first days following registrar's arrival

The following list is not meant to be exhaustive but rather things that registrars have found useful.

The recommendations may be best incorporated into discussions surrounding patients. Most registrars sit in on the consultations of the supervisor over the first few days.

Medicare and billing

- review the different benefit cards held by patients (pension, health care card, Department of Veteran Affairs (DVA), pharmaceuticals)
- explain how your practice deals with billing
- review billing forms (Medicare and DVA).

Writing a script

- explain the mechanics of writing a legal, safe script (such things as crossing off the area between your last item and signature, writing a maximum of three items on the one script, and routine quantities and repeats are often not known by registrars)
- explain the difference between PBS, PBS authority, Department of Veterans Affairs and private scripts, and the difference in cost to patients
- explain how to use the MIMS and pharmaceutical benefits book, and how to access an authority from the Health Insurance Commission (HIC).

Medical records

- work through the medical records with the registrar. Go through the practical aspects of good records, such as date and signature, patient name, summary sheet, results, consultant letters
- explain the filing system/computer system you use for patient records
- explain how results are checked and followed through.

Writing a medical certificate

- discuss the mechanisms of writing a legal sickness certificate and the common pitfalls.

WorkCover

- discuss the concept of WorkCover and the unusual nature of the triad involved
- explain what happens with the pay of the employee and the obligations of the employer to provide appropriate employment
- explain each part of the form and the implications of providing various types of information
- explain the procedure at your practice with billing.

Doctor's bag

- compare the contents of your own doctor's bag with the registrar's. Work through the contents with them
- review the doctor's bag pharmaceutical list and explain how to get what you need.

Home visits

- discuss how home visits are managed in your practice
- bring the registrar on a home visit.

Coordination of care

- review the services of the local hospital or polyclinic you use, and how to find out about them, eg. specialists, hospitals, allied health professionals, investigations, counselling services and community groups
- if the practice is involved in the local hospital or polyclinic, the registrar will need a specific orientation to this as well.

Good orientation can minimise many potential problems and set up a positive framework for a registrar's career in general practice. Hopefully, it will also be an enjoyable time for both you and the registrar to get to know each other.

Reducing risk

The registrars working in your practice are under your supervision, and however you structure that relationship, you carry some liability for the work they do. Ensure your registrar has appropriate medical indemnity, that your medical defence organisation knows you are supervising a general practice registrar, and that you have adequate insurance cover.

The best way to minimise the risk of litigation and, more importantly, of adverse outcomes for your patients, is to ensure your registrar's competence. This can be ascertained by:

- asking about previous experience
- asking about the registrar's perceived competence in various areas, particularly the higher risk areas listed in of *The RACGP standards for trainers and training posts* (standard T.17)
- reviewing the registrar's clinical notes
- reviewing referral letters to consultants
- observing the registrar at work during procedures and consultations.

Litigation is more likely to result from poor communication than from lack of knowledge. Observing your registrar's communication skills and assisting them to improve in this area is of the utmost importance.

Curriculum

Curriculum for general practice training

Background

In recent years the RACGP has increasingly placed emphasis on documenting a formal curriculum which outlines the learning objectives, content, learning activities and other training requirements. This forms the basis of the Australian General Practice Training Program as administered by General Practice Education and Training (GPET) and regional training providers.

Development of a curriculum

The need for a post graduate vocational training program for general practitioners has been identified for many years by the medical profession, academics and those responsible for setting and maintaining standards. From 1973 to 2001, the RACGP training program answered this need.

The program changed considerably during that time, responding to expectations that it provide evidence of graduate competence, clearly state its goals and objectives, place more emphasis on formal assessment, more closely reflect national health priorities and needs, address rural training needs more effectively, and respond more positively to workforce issues.

There has also been increasing emphasis placed on training programs being accountable to the community, government and the profession by documenting the knowledge, skills and attitudes necessary for competent unsupervised general practice. Not only does the identification of the curriculum serve this purpose, it also provides the essential framework for teaching by GP supervisors and medical educators, and an information base for registrars to use in their planning and selection of relevant training experiences.

The curriculum is also a substantial reflection of the unique attributes and characteristics of the discipline of general practice. The curriculum framework described here is a representation of the way in which the dimensions of general practice uniquely combine.

With the advent of GPET, the RACGP curriculum remains the basis of the training program run by regional training providers.

The curriculum will be reviewed and updated during 2005. Copies of the current curriculum can be downloaded from www.racgp.org.au/folder.asp?id=709.

Curriculum definitions

- **curriculum**

The minimum and essential learning experiences, knowledge and skills required for competent unsupervised general practice.

In other words, the curriculum is the sum of the planned learning experiences registrars are expected to have. It includes the rationale, learning objectives, content, learning activities, teaching and assessment approaches, and the structure and sequence of the major program components

- **curriculum statements**

Descriptions of particular parts or areas of the curriculum of the training program.

The curriculum framework

The framework used for development of the curriculum consists of three interrelated dimensions:

- the domains of general practice
- patient presentations
- population health needs and priorities encompassed by the philosophical foundation of general practice (ie. conceptual basis of general practice, critical thinking, research).

Domains of general practice

Five domains collectively reflect the critical areas of general practice. They encompass the knowledge, skills and attitudes appropriate for competent general practice. It is envisaged all teaching and supervision in the training program will actively address each domain, enabling registrars to achieve the identified learning objectives. These domains will also increasingly form the basis of the continuing professional development program for GPs.

The five domains are:

Communication skills and the patient-doctor relationship

Including:

- the nature of the relationship between patient and doctor, and its therapeutic potential
- consultation models
- patient centredness, and the communication skills and attitudes needed to foster effective whole person care
- individualistic and opportunistic health education and promotion.

Applied professional knowledge and skills

Including:

- knowledge of significant medical conditions
- approaches to undifferentiated problems, information gathering, physical examination skills, procedural skills, and clinical decision making
- continuity and integration of care
- cost effective investigations and treatment, and rational prescribing
- critical appraisal of professional knowledge and skills.

Population health and the context of general practice

Including:

- demographics, epidemiology, public health problems, and the health needs of special groups
- population based preventive strategies
- sociopolitical and cultural aspects, and the influence of family, work and significant others on health
- advocacy role
- community resources.

Professional and ethical role

Including:

- special duty of care
- maintenance of professional standards
- contemporary ethical principles
- reflective skills and professional self appraisal
- lifelong learning and continuous professional improvement
- role as a teacher, leader and change agent

- research, evaluation and audit skills
- professional networks
- maintaining wellbeing of self and family.

Organisational and legal dimensions

Including:

- availability and accessibility arrangements
- safety netting, screening and recall systems
- patient and practice related information technology and management
- medical records and legal responsibilities (reporting, certification and confidentiality)
- practice management.

Patient presentations

Most of the work of GPs involves providing advice to individual patients in the treatment and management of medical conditions. Indeed, GPs manage the majority of presentations requiring medical treatment in the community. Therefore, one of the three main dimensions of the framework is presenting conditions or reasons for encounter.

Within this dimension the criteria used to determine the content of the curriculum include:

- problems which significantly contribute to morbidity and mortality
- common presentations which exemplify general practice
- presentations requiring special skills
- health problems which present differently in different groups
- presentations with a public health significance
- health problems which have been shown to be preventable.

Population health needs and priorities

The RACGP has a responsibility to train general practitioners who are able to provide high quality primary health care services that are relevant to individual and community needs. Consequently, the third dimension of the curriculum framework is health needs and priorities in the population. This includes:

- ***national health goals and targets***
 - reducing health inequalities
 - improved access and participation
 - intersectoral action
 - healthy lifestyles
- ***a focus on the four priority areas in mortality and morbidity***
 - cardiovascular health
 - cancer control
 - injury prevention and control
 - mental health
- ***indigenous health***
- ***HIV/AIDS***

Identified curriculum priority areas

The curriculum framework as described above provides the basis for identifying curriculum priority areas.

Intellectual and philosophical foundations

- conceptual basis of general practice
- critical thinking and research.

Acute and chronic presentations

- acute and traumatic conditions
- chronic conditions
- mental health.

Gender

- women's health
- men's health.

Age

- health of children and young people
- aged care.

Groups with special needs

- indigenous health
- ethnicity specific health.

How you can use the curriculum documents

- quickly read the content section of each statement (eg. chronic conditions or aged care) to find which areas you need to cover with the registrar in your teaching sessions and clinical record reviews, or if there are consultations which would be valuable for them to observe
- look through the learning objectives and assessment sections in the core curriculum and refer to the log book to ascertain which particular practical procedures the registrar needs to observe and perform
- read the teaching and learning approaches section for ideas on teaching strategies
- use the document to give the registrar an idea of the scope and depth of understanding needed to address the needs of a particular patient by referring them to a range of relevant statements and sections
- discuss with medical educators (eg. at general practice trainer workshops, following an external clinical teaching visit, over the phone) which areas are most appropriately covered in your teaching sessions or in direct practice experience, and which areas you feel are not appropriate or easily covered.

Practice based teaching

Many GPs express their concern about not knowing how to teach. However, the core of teaching is communication skills – GPs who know how to talk with and listen to patients have already developed the core skills needed. The next step is the development of a structured, interesting and effective process to make teaching and learning easier, more enjoyable and effective for general practice trainers and registrars.

When thinking about teaching, consider:

- characteristics of adult learners
- the stage the learner is at, eg. basic or advanced
- the background of the general practice registrar
- the preferred learning style of the registrar
- the registrar's learning objectives for that term
- the RACGP curriculum
- the time and resources available.

Characteristics of adult learners

- adults learn best by doing, so when teaching a skill consider a method which allows the learners to perform that skill
- adults learn best when they are able to participate, so consider a method which allows interaction between the learner and yourself
- adults learn best when they are able to relate the topic to their own experience or practice, so consider a method which allows them to participate and discuss their own experiences
- adults need to see the relevance of what they are learning to their own practice, so consider a method which sets real practice problems or allows the participants to discuss their own practice problems with you
- adults need to feel in control of their learning environment, so consider a method which allows involvement in setting learning objectives and allows them to have some control over the methods and topics used
- adults learn more rapidly and effectively if they receive constructive feedback, so consider methods that include constructive feedback.

Self directed learning

General practice training is centred around the RACGP curriculum. General practice registrars are encouraged to negotiate their own learning objectives with their supervising practices. It is hoped that general practice registrars will then acquire lifelong habits of looking at themselves critically, and planning their own continuing education.

During the first week of term it is advisable to spend time with the general practice registrar discussing their learning objectives and what they see as their weaknesses and strengths. From here a plan of how the teaching sessions and practice can be utilised to achieve these aims can be devised. It may be helpful to use a learning plan proforma to assist in this process (see page 16).

As well as planning what to learn, the general practice registrar needs to assess how he or she is progressing in meeting these objectives, and identify previously unrecognised areas of weakness which will form the basis of further learning objectives. This requires continuing assessment of the general practice registrar's performance by the trainer, and constructive feedback to the general practice registrar.

Learning styles

When planning to implement education within a general practice, it is useful to consider 'how' the individual learns. Honey and Mumford in their *Manual of learning styles*¹ extended Kolb's inventory of different learning styles², classifying individuals into four different learning preferences:

- an *activist* enjoys new experiences but becomes bored with long term implementation. In educational terms an activist will enjoy group work, participating and contributing to discussions, but will have a tendency to jump in without thinking
- a *reflector* prefers to consider all options carefully before acting and will collect data carefully and methodically. In educational terms a reflector will wait before contributing to a discussion or group work until he or she has all the available information
- a *theorist* likes analysing and constructing models to explain what is happening before acting. In educational terms a theorist would enjoy lectures with models of general practice
- a *pragmatist* prefers experiences that have a practical value. In educational terms a pragmatist would prefer demonstrations and practical experience.

Most people are not necessarily limited to one particular style but show a dominance in one or two areas; others may be evenly divided between the four.

There is a tendency among most educators to teach according to their own preferred learning style, irrespective of the style of the learner.

A study by Lewis and Bolder in Britain suggested that GP educators come from one group of learning preferences with dominance in the reflector/theorist area, whereas general practice registrars and nontrainer GPs come from a different group of predominantly reflector/pragmatists. These differences were statistically significant. If the learner's style differs from the educator the teaching and learning process may become frustrating for both.

Learning styles questionnaire

This questionnaire is designed to assess your preferred learning style(s), which you will need to know prior to coming to the training day. Over the years we all develop preferred learning habits which mean we benefit more from some experiences than from others. We tend to be unaware of this preference. This questionnaire will help you pinpoint your learning preferences and the types of learning experience that suit your style. The first step in helping others to learn is understanding how you like to learn, because that shapes your expectations of others.

There is no time limit to this questionnaire. It will probably take you 10–15 minutes to complete. The accuracy of the results depends on how honest you can be. There are no right or wrong answers.

If you agree with a statement more than you disagree, answer with a **tick**. If you disagree more than you agree, answer with a **cross**. Be sure to mark each item with either a tick or cross.

- | | | |
|---|--|--------------------------|
| 1 | I have strong beliefs about what is right and wrong, good and bad. | <input type="checkbox"/> |
| 2 | I often act without considering the possible consequences. | <input type="checkbox"/> |
| 3 | I tend to solve problems using a step by step approach. | <input type="checkbox"/> |
| 4 | I believe that formal procedures and policies restrict people. | <input type="checkbox"/> |
| 5 | I have a reputation for saying what I think, simply and directly. | <input type="checkbox"/> |
| 6 | I often find that actions based on feelings are as sound as those based on careful thought and analysis. | <input type="checkbox"/> |
| 7 | I like the sort of work where I have time for thorough preparation and implementation. | <input type="checkbox"/> |
| 8 | I regularly question people about their basic assumptions. | <input type="checkbox"/> |

1 Honey P, Mumford A. The manual of learning styles. Maidenhead: Horney, 1986.

2 Kolb D. Experimental learning: experience as the source of learning and development. New Jersey: Prentice-Hall, 1984.

- 9 What matters most is whether something works in practice.
- 10 I actively seek out new experiences.
- 11 When I hear about a new idea or approach I immediately start working out how to apply it in practice.
- 12 I am keen on self discipline, eg. watching my diet, taking regular exercise, sticking to a fixed routine.
- 13 I take pride in doing a thorough job.
- 14 I get on best with logical, analytical people and less well with spontaneous, irrational people.
- 15 I take care over the interpretation of data available to me and avoid jumping to conclusions.
- 16 I like to reach a decision carefully after weighing up many alternatives.
- 17 I'm attracted more to novel, unusual ideas than to practical ones.
- 18 I don't like disorganised things and prefer to fit things into a coherent pattern.
- 19 I accept and stick to laid down procedures and policies so long as I regard them as an efficient way of getting the job done.
- 20 I like to relate my actions to a general principle.
- 21 In discussions I like to get straight to the point.
- 22 I tend to have distant, rather formal relationships with people at work.
- 23 I thrive on the challenge of tackling something new and different.
- 24 I enjoy fun loving, spontaneous people.
- 25 I pay meticulous attention to detail before coming to a conclusion.
- 26 I find it difficult to come up with wild, off the top of my head ideas.
- 27 I believe in getting to the point immediately.
- 28 I am careful not to jump to conclusions too quickly.
- 29 I prefer to have as many sources of information as possible – the more data to think over, the better.
- 30 Flippant people who don't take things seriously enough usually irritate me.
- 31 I listen to other people's points of view before putting my own forward.
- 32 I tend to be open about how I'm feeling.
- 33 In discussions I enjoy watching the manoeuvrings of the other participants.
- 34 I prefer to respond to events on a spontaneous, flexible basis rather than planning things out in advance.
- 35 I tend to be attracted to techniques such as network analysis, flow charts, branching programmes and contingency planning.
- 36 It worries me if I have to rush out a piece of work to meet a tight deadline.
- 37 I tend to judge people's ideas on their practical merits.
- 38 Quiet, thoughtful people tend to make me feel uneasy.
- 39 I often get irritated by people who want to rush things.
- 40 It is more important to enjoy the present moment than to think about the past or future.
- 41 I think that decisions based on a thorough analysis of all the information are more sound than those based on intuition.
- 42 I tend to be a perfectionist.
- 43 In discussions I usually produce lots of spontaneous ideas.

- 44 In meetings I put forward practical realistic ideas.
- 45 More often than not, rules are there to be broken.
- 46 I prefer to stand back from a situation and consider all the perspectives.
- 47 I can often see inconsistencies and weaknesses in other people's arguments.
- 48 On balance, I talk more than I listen.
- 49 I can often see better, more practical ways to get things done.
- 50 I think written reports should be short and to the point.
- 51 I believe that rational, logical thinking should win the day.
- 52 I tend to discuss specific things with people rather than engaging in social discussion.
- 53 I like people who approach things realistically rather than theoretically.
- 54 In discussions I get impatient with irrelevancies and digressions.
- 55 If I have a report to write I tend to produce lots of drafts before settling on the final version.
- 56 I am keen to try things out to see if they work in practice.
- 57 I am keen to reach answers via a logical approach.
- 58 I enjoy being the one that talks a lot.
- 59 In discussions I often find I am the realist, keeping people to the point and avoiding wild speculations.
- 60 I like to ponder many alternatives before making up my mind.
- 61 In discussions I often find I am the most dispassionate and objective participant.
- 62 In discussions I'm more likely to adopt a low profile than to take the lead and do most of the talking.
- 63 I like to be able to relate current actions to a longer term bigger picture.
- 64 When things go wrong I am happy to shrug it off and 'put it down to experience'.
- 65 I tend to reject wild, spontaneous ideas as being impractical.
- 66 It's best to think carefully before taking action.
- 67 On balance, I do the listening rather than the talking.
- 68 I tend to be tough on people who find it difficult to adopt a logical approach.
- 69 Most times I believe the end justifies the means.
- 70 I don't mind hurting people's feelings so long as the job gets done.
- 71 I find the formality of having specific objectives and plans stifling.
- 72 I'm usually one of the people who puts life into a party.
- 73 I do whatever is expedient to get the job done.
- 74 I quickly get bored with methodical, detailed work.
- 75 I am keen on exploring the basic assumptions, principles and theories underpinning things and events.
- 76 I'm always interested to find out what people think.
- 77 I like meetings to be run on methodical lines, eg. sticking to laid down agenda.
- 78 I steer clear of subjective or ambiguous topics.
- 79 I enjoy the drama and excitement of a crisis situation.
- 80 People often find me insensitive to their feelings.

Learning styles questionnaire scoring

Score one point for each item you ticked. There are no points for items you crossed.

Simply indicate on the lists below which items were ticked.

2	7	1	5
4	13	3	9
6	15	8	11
10	16	12	19
17	25	14	21
23	28	18	27
24	29	20	35
32	31	22	37
34	33	26	44
38	36	30	49
40	39	42	50
43	41	47	53
45	46	51	54
48	52	57	56
58	55	61	59
64	60	63	65
71	62	68	69
72	66	75	70
74	67	77	73
79	76	78	80
<hr/>			
TOTAL			
<hr/>			
Activist	Reflector	Theorist	Pragmatist

Place your scores in the appropriate boxes in the table below. Remember you are not necessarily limited to one particular style – you may find you have a strong preference for one or two styles, or be evenly divided between the four. Read the description of your most preferred styles on page 10 to see if you agree these actually are your most preferred styles. Read the other descriptions as well, so you can understand how other people prefer to learn. Recognising your own learning style is the first step towards adapting your teaching style to both accommodate and challenge the learner's own style.

Style	Very strong preference	Strong preference	Moderate preference	Low preference	Very low preference
Activist	13–20	11–12	7–10	4–6	0–3
Reflector	18–20	15–17	12–14	9–11	0–8
Theorist	16–20	14–15	11–13	8–10	0–7
Pragmatist	17–20	15–16	12–14	9–11	0–8

The learner's style

When considering how to deliver learning and teaching in your practice, it is useful to ask the following questions:

- what is the learner's preferred way of learning?
- what methods of teaching and learning could you use to suit the learner's style?
- are there areas where the learner should be challenged to stretch their abilities? For example, you may encourage an activist (who will enjoy brainstorming many possibilities) to settle on one or two likely differential diagnoses.

The learner may well have a different learning style to the educator, and if this difference is not recognised frustration often results. By recognising your own and the learner's style of learning, you can design a teaching experience that is satisfying for both parties.

Planning teaching and learning in a general practice

Planning teaching and learning in a general practice involves identifying learning needs from various sources, reflecting on these learning needs, negotiating learning goals, and developing a learning plan. Responsibility for this is shared between learner and supervisor, with negotiation a central element. The learner progressively takes more responsibility as their experience increases with the final goal being self directed learning, one of the fundamental philosophies of general practice today.

Successful self directed learning is generally a skill acquired gradually, and medical students and general practice registrars will have varying levels of expertise in this area. A fully self directed learner will be able to identify learning goals themselves after some brief discussion, while other learners will require active direction by the supervisor.

Negotiation

General practitioners negotiate every day: with patients as to whether to prescribe antibiotics; with practice staff about working conditions; and with other partners and associates.

However, many GPs do not recognise negotiation with learners as such. This may be because of the traditional hierarchical system of medicine. Medical students learn to do what they are told, and when they progress through levels of the hierarchy they expect those below them to do the same.

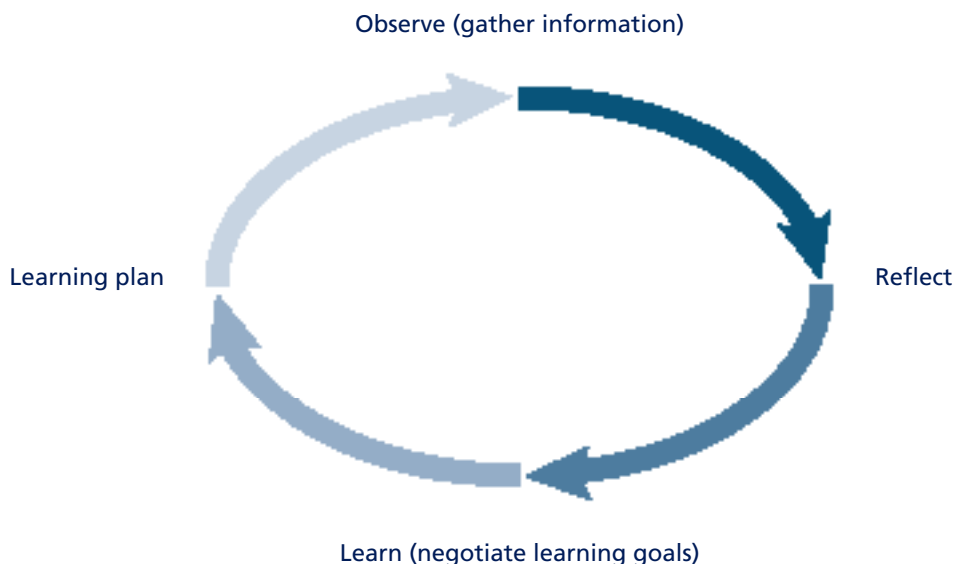
Negotiating teaching and learning allows the learner more control over their own learning, encourages reflection, leads to clearer teaching and learning goals, and develops the learners' skills in negotiation. Negotiation skills are useful in other situations (for example collaborating with other health professionals) and encourages communication between learner and supervisor.

Negotiating teaching and learning is a collaborative process, where there are no right answers or solutions. Supervisor and learner formulate a learning plan together. Throughout the process, the learner maintains control over decision making, with the supervisor encouraging reflection.

Planning teaching and learning

Planning teaching and learning is a continuous process, one that begins at the beginning of the term and is continually re-evaluated.

The process can be illustrated as an adaptation of the 'feedback cycle':



The following sections offer a suggested guide for developing learning and teaching plans.

Identifying learning needs

When identifying learning needs, there are three main sources of information: the learner, the practice and the educational program the learner is undertaking.

The learner

The first step is considering how self directed the learner is, or how much direction is required. This will influence how you go about identifying learning needs.

Self directed learners will:

- seek opportunities to review progress
- seek information from other sources, eg. books, CD-ROMs
- seek feedback
- demonstrate change in response to feedback
- require less input from the supervisor.

The next step is determining what stage of their learning the registrar or medical student is currently at. There are a number of aids which may help you and the learner determine their progress thus far, including:

- the learner's CV
- feedback from patients, staff or partners
- direct or video observation
- file review.

Most important is to establish self identified learning needs. Questions to assist the learner in doing this may include:

- what knowledge and skills do you want or need to develop this term?
- what do you think your strengths and weaknesses are?
- what particular opportunities exist in this practice to develop particular skills?
- what clinical skills do you need to develop?
- what areas do you want particular teaching time in?
- how competent do you feel in particular areas?

The practice

The needs of your practice will depend on geographic situation, referral resources, partners, patient profile, and cultural and socioeconomic surrounds of your practice. For example, if you were in a solo practice in Mt Isa, you might like the learner to quickly become aware of issues related to Aboriginal and Torres Strait Islander health.

The educational program

Both medical students and general practice registrars are adult learners undertaking a structured progressive program that will take them from one knowledge point to another. Be familiar with the learner's curriculum. It contains the skills, knowledge and attitudes the learner will need to acquire to become a competent practitioner. While the curriculum is far too large to be covered in one general practice term, it is useful as a guide to what topics and objectives to cover for a particular topic.

Reflection

Reflecting on the identified learning needs allows time to look for patterns, and consider issues more broadly. The supervisor may use questions to encourage clarification of goals and plans. This process requires a balance of challenge and support so the learner feels stimulated, rather than resentful or defensive.

Questions which may be useful to encourage reflection include:

- why is a particular topic important?
- why did you choose this topic?
- what do you feel is your preferred learning style?
- is it the content or process that you feel you are strongest in (eg. consultation skills)?
- is this a topic you already know a lot about? Should you choose a topic that may extend you more?
- what are some areas you feel unsure about?
- what could you do to find out more about a particular topic?

Negotiating learning goals

Negotiation is a continuation of the reflection process. Both learner and supervisor contribute to the development of learning goals. The learner should have control over the decision making, with the supervisor providing guidance, support and pass on the benefit of experience to ensure the learner's goals are achievable in the time frame and in the particular practice.

For example, should the learner wish to learn about child development assessment, but the practice has an aged care orientation, the supervisor should either find a way to achieve this objective or suggest a change.

This process will depend on how self directed the learner is, as relatively inexperienced learners may need the supervisor to have greater input.

Formulating a learning plan

A learning plan should include strategies for achieving identified learning needs. The plan may include practicing a technique, researching a topic, contacting a specialist, or the use of other teaching methods such as observation of the consultation, topic tutorials or a practice audit.

Learning plan example

Following is a possible format for a learning plan. Please note, this is a guide only; the same issues can be covered and documented differently.

Practice:	
<hr/>	
General practitioner trainer:	Dates:
<hr/>	
Nature of placement (eg. size, location, profile, specialties):	
<hr/>	
<hr/>	
Identifying learning needs	
Practice requirements:	
<hr/>	
<hr/>	
Educational program requirements:	
<hr/>	
<hr/>	
About the learner:	
<hr/>	
<hr/>	
<hr/>	
Questions may include:	
<ul style="list-style-type: none"> • what knowledge and skills do you want or need to develop this term? • what clinical skills do you need to develop? • what areas do you want particular teaching time in? • how competent do you feel in particular areas? 	
<hr/>	
Reflection	
<ul style="list-style-type: none"> • why is a particular topic important? • what do you feel is your preferred learning style? • is it the content or process that you feel you are strongest in? • how do you plan to have sufficient exposure to your areas of need? • how are you going to go about the learning and teaching process? 	
<hr/>	
Learning goals	Strategies
	May include practising a technique, researching a topic, contacting a specialist, or the use of other teaching methods such as observation of the consultation, topic tutorials or a practice audit.
1.	1.
<hr/>	<hr/>
2.	2.
<hr/>	<hr/>
3.	3.
<hr/>	<hr/>
4.	4.
<hr/>	<hr/>
5.	5.
<hr/>	<hr/>

Structured teaching time

Structured teaching time is dedicated time set aside for teaching. While spontaneous teaching is a common and useful method in a general practice, structured teaching time is essential in achieving organised and focused learning. This method has advantages for both the learner and the supervisor, so it is important to develop strategies for maximising the effectiveness of planned teaching time.

Why structured teaching time?

Time set aside for teaching takes into account the individual needs of the learner and the particular learning opportunities offered by the practice while ensuring that teaching does occur. It may also act as an effective time management tool. The busier the practice, the greater the need to have planned time for teaching. Unplanned teaching time often becomes a casualty to clinical demands.

Planned teaching sessions (perhaps two per week) greatly reduce the number of spontaneous inquiries from learners, which often occur when everyone is otherwise occupied. For most learners, knowing they will have the opportunity to discuss cases with their supervisors eliminates all but the urgent questions.

Advantages	Limitations
<ul style="list-style-type: none"> ensures time is allocated to teaching targets learner's needs reduces the number of enquires from learner allows for curriculum topics to be delivered 	<ul style="list-style-type: none"> less likely to be based on actual practice time required for preparation

What can be covered in a structured teaching session?

- curriculum topics
- identified learning objectives
- review of cases chosen either at random or selected because of their content
- audit of referrals, with discussion on the need for them and planned follow up
- audit of pathology/radiology, their cost effectiveness and relevance to general practice
- direct observation of learner by supervisor or vice versa
- video debriefing of previously taped consultations
- in depth discussion of topics raised by learner or identified during case review
- review of learner's learning plan
- practice management
- joint nursing home visits or house calls (these are especially useful during the first few weeks of the term).

Strategies for maximising the effectiveness of structured teaching time

- set aside time which is mutually agreeable to both the learner and supervisor (eg. during consulting hours; arrange regular sessions over lunch)
- ensure all practice staff are aware of and respect the structured teaching time
- involve other medical staff in the practice specific sessions on topics where they have expertise
- use a variety of teaching and learning methods.

Teaching and learning methods

A teaching and learning method is a type of activity used to facilitate teaching and learning. This section will describe the potential application of several different teaching and learning methods.

Deciding what method to use

When deciding what method to use, consider:

- **characteristics of adult learners**

See the explanation of characteristics of adult learners on page 9.

- **suit the method to the particular objective**

The teaching and learning method chosen should be appropriate to the particular subject or objective. For example, if the objective involves the learner acquiring practical skills, a practical teaching and learning method that involves the learner actually performing the skill may be more suitable than a case study.

- **how learning links with the curriculum**

Both medical students and general practice registrars are adult learners undertaking a structured progressive program that will take them from one knowledge point to another. The curriculum provides the structure for this progression, and the selection of topic and method should link in with the curriculum.

- **what stage the learner is at**

The teaching and learning method chosen should be appropriate to the medical student or general practice registrar's current level of knowledge. At different stages of the progressive structure, different levels of supervision are necessary.

- **the time and resources available.**

All teaching is limited by the time and resources available, and this can have a major impact in a busy general practice. While opportunistic teaching is an important part of teaching in a general practice, avoid relying on the 3 minute lecture. Such encounters are limited and can not serve as a replacement for a well thought out plan that uses a variety of methods.

Commonly used teaching and learning methods in a general practice

Method	Advantages	Limitations	Useful for
Direct observation of the consultation	<ul style="list-style-type: none"> • reflection on practice is encouraged • allows you to know exactly what goes on in a consultation • relates to real practice and real problems • videotaping • video may be reviewed in own time, location and pace 	<ul style="list-style-type: none"> • may be threatening or uncomfortable • requires time and ability to reflect 	<ul style="list-style-type: none"> • interview skills • examination skills • manual skills • patient education • doctor patient relationships • evaluation of self
Constructive feedback	<ul style="list-style-type: none"> • based on actual practice • can raise self awareness • builds on what the learner is doing • facilitates interaction between the learner and supervisor 	<ul style="list-style-type: none"> • may cause resentment if poorly done 	<ul style="list-style-type: none"> • interview skills • examination skills • patient education • doctor patient relationships • ability and willingness to evaluate self

Method	Advantages	Limitations	Useful for
Learning profiles/ portfolios	<ul style="list-style-type: none"> relates to real practice opportunity to understand own practice 	<ul style="list-style-type: none"> requires time and ability to reflect 	<ul style="list-style-type: none"> describing critical incidents recording specific learning experiences reflecting on own practice and improve self awareness identifying learning needs enlarging perceptual concepts
Topic tutorials	<ul style="list-style-type: none"> can target identified learning objectives can augment other modes can update knowledge on specific topics 	<ul style="list-style-type: none"> preparation required to be effective 	<ul style="list-style-type: none"> updating knowledge specific topics eg. alcohol, sexual abuse
Case discussion	<ul style="list-style-type: none"> based on actual practice allows interchange of ideas can cover key cases or problem cases focus on problem solving skills informs the supervisor about the learners practice 	<ul style="list-style-type: none"> potential for learner to be passive can become outcome focused 	<ul style="list-style-type: none"> problem solving skills appropriateness of investigation, management continuity of care family perspective community perspective tolerance for uncertainty interpretation of data
Practice audits	<ul style="list-style-type: none"> based on actual practice encourages reflection may provide useful information to the practice 	<ul style="list-style-type: none"> time consuming some methodological knowledge required looks at only one area of practice 	<ul style="list-style-type: none"> organisation of records and reports data base family orientation continuity preventive orientation therapeutic choice
Demonstration	<ul style="list-style-type: none"> can relate to real practice situation learner can participate and learn by doing allows immediate feedback and discussion 	<ul style="list-style-type: none"> expensive in terms of time and resources 	<ul style="list-style-type: none"> hands on procedures consulting, interviewing or counselling
Role plays and simulations	<ul style="list-style-type: none"> acts out real life situation in a protected or risk free environment provides a focus for discussion learner is active rather than passive time spans can be compressed 	<ul style="list-style-type: none"> learner and/or supervisor may feel uncomfortable if unfamiliar with method 	<ul style="list-style-type: none"> procedural skills consulting, interviewing or counselling difficult patients the art of general practice attitudinal changes

Direct observation of consultations

Observing a registrar's consultations (either by sitting in or by video taping) and providing feedback on them is an important teaching and learning method within the general practice. Carried out regularly it facilitates an environment where reflection on practice is encouraged and allows the supervisor to give specific feedback. No other method of teaching will allow you to know exactly what goes on when the learner is consulting with your patients.

There are three components to direct observation of consultations: preparation, analysing observed consultation, and giving constructive feedback.

Preparation

- **teaching requires time and planning**

The receptionists usually control the allocation of time in a practice, so ensure the receptionist understands the high priority of teaching

- **prepare the learner**

Most people find direct observation uncomfortable. Attempt to allay the learner's fears by explaining the steps in observation. It may help to explain the model of feedback you will be using

- **brief the patient**

In seeking consent, a short printed explanation given to the patient before the consultation is an excellent way of informing them in advance of the consultation. This increases patients' opportunity to exercise their freedom to choose whether there is an observer present, and avoids unintended influence. This should be followed up by a brief verbal explanation by the learner and consent should be confirmed

- **if videotaping, prepare the equipment**

The camera should be positioned on a tripod or platform in such a way that both doctor and patient are visible. If impossible, position the camera so the patient rather than the doctor can be seen. The camera should not be directed towards a source of light. If your room is too small, you could buy a wide angle lens or use a mirror (aim your camera into the mirror to double the distance and get a better view). Before recording begins, make a short recording and replay to test the picture and sound.

Analysing the observed consultation

Practical tips

- don't look directly at the patient. Sit out of the direct line of site of the patient
- leave comments until after the consultation, unless the learner is about to commit a major act of negligence or indecency
- write notes on different elements of the consultation.

Introduction

Analyse:

- how the learner sets the tone for the interview
- the form of greeting used
- the first words uttered by the patient and the learner's response to these
- the form of address chosen
- seating posture and eye contact.

History taking techniques

Analyse:

- use of open ended versus closed questions
- time taken and techniques used to get from social chit chat to business
- control of the consultation – whether the patient gets to tell their story, or the doctor determines the agenda.

Physical examination

- remember some patients may not wish to have another person present during physical examinations.

Management plan

- investigations and therapy are often discussed as well as avoiding the use of jargon.

Follow up

- often requires detailed discussion, particularly with inexperienced learners. Continuity of care and initiating follow up may be new responsibilities for some learners.

Time management

Discuss:

- how to increase time efficiency without decreasing performance
- dealing with interruptions such as telephone calls
- following up on specialist visits
- dealing with difficult patients, angry patients, noncompliers, disruptive children
- booking and record systems.

Medical records

- a useful strategy is for the supervisor to make medical notes as he/she observes the consultation and compare them with the learner's notes at the end of the consultation.

Preventive health

- every observed consultation can become the focus for discussion on preventive health aspects for that patient. An awareness of the commonest causes of mortality for each age group can help focus the relevant preventive issues.

Constructive feedback

One of the most important teaching behaviours in a general practice is giving feedback to general practice registrars or medical students on their performance. Constructive feedback is designed to encourage reflection by the learner and provide information about current performance that can be used to improve it in the future.

Receiving feedback can be threatening for some learners, and giving feedback can be uncomfortable for some supervisors. To be constructive, feedback should follow a planned structure that promotes an open, honest and supportive environment.

Strategies for maximising the effectiveness of feedback

- follow a suitable model of giving feedback that you are comfortable with
- provide feedback as soon after the event as possible
- plan feedback allowing sufficient time
- comment only on things that you have observed, and comment on the action, not the person
- avoid being judgemental, or colluding by being too positive
- use questions rather than statements to encourage reflection
- start with general observations and move on to the specifics of the consultation/case discussion
- limit your agenda – don't try to cover too much at once.

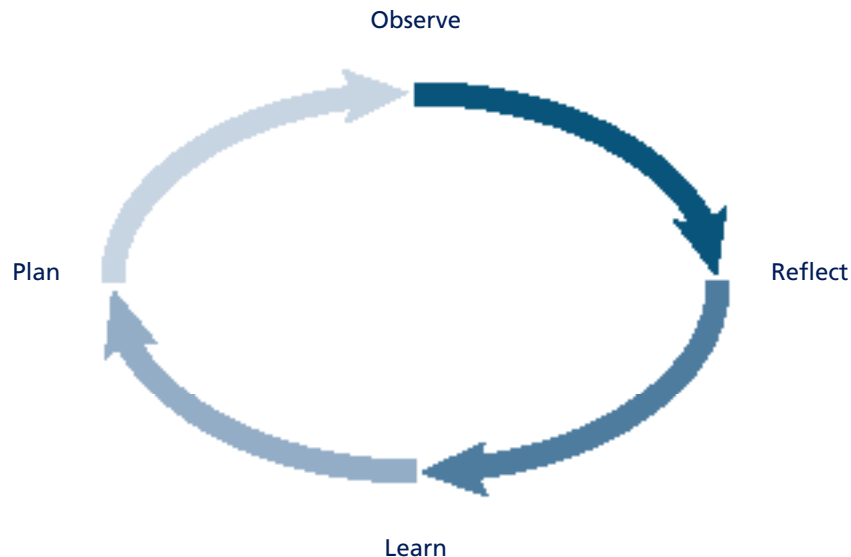
Models of feedback

The following are descriptions of three recommended models of feedback: the feedback cycle (an adaptation of Kolb's learning cycle); Pendleton's rules; and five step microskills.

Any of the three could be used for medical students or general practice registrars. Choose the model that you are most comfortable with.

Feedback cycle

The following are ways discussion can be stimulated following observation of the consultation:



Setting the agenda for discussion

Discuss and negotiate the agenda and set priorities for discussion. This does not have to be a complex process. A few simple questions or statements (eg. 'What would you like to discuss about the consultation?' or 'The things I would like to talk about are...') may be useful to begin discussion.

Reflection

This involves reflecting on the issues raised by the agenda items. It is time to look for patterns, clues to understanding and for thinking broadly. This process requires a balance of challenge and support so the practitioner feels stimulated to learn rather than resentful and defensive. Questions that might be useful to encourage reflection are:

- what are your usual ways of opening a consultation?
- how do you think this patient responded to the technique you used this time?
- I wasn't certain what you were looking for when you asked...
- what has been your teaching so far on...?
- how do you think the results of the test you ordered will alter your management?
- what did the patient do to make you offer an alternative treatment?

Identify learning progress and needs

Identify lessons learned, and learning needs/opportunities for learner and observer. Much learning progress will be identified during the reflection process. It will be obvious and will occur informally; it may not be necessary to make a list of everything that has been learned. However, the level of new knowledge and understanding may need to be clarified in order to identify those things which still require learning.

Formulate a learning plan

This involves developing a learning plan with strategies for identified learning needs. The plan may include practicing a technique, researching a topic, contacting a specialist or the use of other teaching methods such as topic tutorials, case studies or a practice audit.

The feedback cycle is seen as complete when a new behaviour is observed in a subsequent consultation.

Example

After discussion the observer and the learner agreed for the observer to concentrate on communication skills between the learner and patient. At the end of the consultation the observer asked questions, such as 'What are your usual ways of opening a consultation?' and 'How do you think this patient responded to the technique you used this time?' It was agreed that while the learner had a pleasant manner with patients, there was a tendency to ask mostly closed questions. A list of closed questions used was jointly generated and changed into open questions. These were placed on the learner's desk and an agreement made to discuss the results of asking at least one of them in each subsequent consultation.

Pendleton's rules

Step 1

Trainer asks registrar, 'What do you believe you did well in that consultation?'

Step 2

Trainer then offers, 'Well, these are the things that I thought you did well.'

Step 3

Trainer then asks registrar, 'What would you do differently if you had the opportunity to take the consultation again?'

Step 4

Trainer then tells the registrar what he/she might have done differently and explores these points with the registrar.

Example

You have just observed one of the learner's consultations. The patient is a woman aged 23 years, new to the practice, and presents complaining of a cold for a few days and pain in her maxillary sinuses. After his opening question, the registrar launches into questions about her past health, family history, smoking and alcohol use. You notice that the patient becomes a little impatient during this time. Eventually, the learner gets back to the presenting complaint and after an adequate examination, explains his diagnosis of sinusitis and prescribes erythromycin with instructions regarding how to take it. However, he does not mention any side effects. He does arrange appropriate follow up.

Possible discussion points for this consultation:

- things done well:
 - information gained
 - diagnosis and management.
- things to do differently:
 - timing and extent of health summary information
 - doctor-patient communication with respect to nonverbal cues
 - side effects of medications.

Following Pendleton's rules, feedback may progress like this:

- *step 1*: 'What do you believe you did well in that consultation?' The registrar will probably identify the good points.

- *step 2:* 'Well, these are the things that I thought you did well.' When the good points are identified, expand on them. For example, after discussing the value of obtaining a health summary, ask why it is good idea to explain how to take antibiotics.
- *step 3:* 'What would you do differently?' Follow up with a question on why they feel that aspect should have been done differently; what the advantages or disadvantages of doing it that way might be; whether there are situations where that approach is appropriate and effective.
- *step 4:* If the learner does not identify areas to change, you need to raise them as per step 4 of Pendleton's rules. However, introduce the subject from a broad perspective and if possible by linking it to something discussed earlier. For example, 'We've already discussed the value for us of taking a health summary, but what do you think our patients feel about being asked all these questions?' or 'What are the advantages and disadvantages of asking all those questions at our first meeting with this patient?'

Using the same approach when discussing the lack of information regarding side effects of erythromycin, you could start from a very general perspective. For example, 'When we consider the management phase of the consultation, what should it include?' Then, 'If we look at the treatments we prescribe, what information should we make sure our patients have?'

Five step microskills

Step 1 – get a commitment

Encourage the general practice registrar or medical student to make a commitment to a diagnosis, work up or treatment plan. This promotes problem solving skills. For example, 'What do you think is going on? Why do you think this patient is noncompliant?'

Step 2 – probe for supporting evidence

Encourage reflection on the mental processes used to arrive at that decision. For example, 'What did you take into account when making that decision?'

Step 3 – teach general rules

Take a general approach so information is readily transferable to other situations. For example, 'With cellulitis, incision and drainage is not possible.'

Step 4 – reinforce what was done right

Reinforcement of positive behaviour will result in these behaviours being repeated. Positive feedback early on also makes negative feedback easier later.

Step 5 – correct mistakes.

Correcting mistakes is quite deliberately the last step. Correcting mistakes is very important, but it is only one part of the feedback and requires tact to be effective. Ask the learner to critique their own performance first. However, if the learner does not raise a problem, be prepared to raise it yourself. Where possible, frame mistakes as 'not best' rather than 'bad'.

Learning profiles/portfolios

Learning profiles are self directed reflective activities. They involve keeping diaries or journals about learning activities, critical incidents and problems learners have encountered, and spending time considering practice and professional issues. Through this process, the learner becomes aware of their own practice, recognising patterns of events and their responses to these, and identifying learning needs. Learning experiences can be enhanced by writing and reflecting on a learning profile.

Advantages	Limitations	Useful for
<ul style="list-style-type: none"> • self directed • relates to real practice • opportunity to understand own practice • may facilitate interaction between the learner and supervisor 	<ul style="list-style-type: none"> • requires time and ability to reflect 	<ul style="list-style-type: none"> • describing critical incidents, ie. incidents that have some significance or impact, positive or negative • recording specific learning experiences • reflecting on own practice and improving self awareness • identifying learning needs • enlarging perceptual concepts

Although some learners may wish to keep them private, learning profiles are most productive when discussed regularly with the supervisor. Learning profiles facilitate interaction between the learner and supervisor and are often the source of interesting and stimulating discussions. Supervisors have found learning profiles to be a useful tool to kick start and guide the learning process in their practice.

Introducing learning profiles in a general practice

- discuss the concept of learning profiles with the learner
- if agreeable, ask the learner to note some of the following:
 - learning activities
 - what they learned about a chosen topic each day
 - what else they would like to learn about that topic
 - the most negative experience of the day
 - the most positive experience of the day
 - interesting items from professional journals.
- encourage learner to take clippings from journals, magazines, newspapers (political issues relating to general practice may be interesting and valuable)
- discuss the above issues with the learner on a regular basis
- be sensitive towards the privacy of the learner; there may be parts of the learning profile they are not comfortable showing you.

Topic tutorials

Topic tutorials are periods of instruction on particular topics given by an experienced practitioner to one or two learners. Traditional formats saw the expert speak and the learner listen, however, recently tutorials have become more interactive and learner centred, following the principles of adult learning. Topic tutorials can be of considerable value particularly for updating knowledge on specific topics like alcohol or sexual abuse. This paper will discuss the strategies for maximising the effectiveness of topic tutorials and will list steps in planning a tutorial.

Advantages	Limitations
<ul style="list-style-type: none"> • can target identified learning objectives • can augment other modes • can update knowledge on specific topics 	<ul style="list-style-type: none"> • preparation required to be effective

Strategies for maximising the effectiveness of topic tutorials

- encourage active participation throughout the tutorial, with the use of open questions
- use a variety of resources, eg. videos
- choose topics that:
 - tie into the learner's release or education program
 - are of particular relevance to your practice
 - you have an interest in.
- encourage the learner to 'teach' the topic
- prepare for the tutorial and encourage the learner to also prepare
- choose topic well ahead of time
- avoid overwhelming the learner, eg. don't conduct tutorials every day.

Planning tutorials

- **topic**

Decide what area you want to cover, consider the needs of the learner, your practice and the educational program. Negotiate topic with the learner

- **time**

What time do you have for this session, eg. 1 hour, 90 minutes

- **aim**

Work out the overall aim of the session, eg. the learner will be able to outline the management of asthma

- **objectives**

The objectives are the steps that need to be taken to achieve the overall aim. They should cover the skills, attitudes and knowledge the learner should have at the end of the session, ie. results, not activities.

An example of an objective is: 'Participants will be able to list the main drugs used in the management of asthma'.

Use action words, eg. 'Participants will be able to: outline, discuss, identify, define, list, explain, demonstrate, examine and compare...'

- **strategies**

Write out step by step what strategies you will use for the session and connect them to the objectives.

Think about how can you make it more interesting, and how can you incorporate adult learning principles.

For example, watch video on the presentation of asthma; brainstorming main drugs used in asthma and their role; case study of a patient with asthma; develop a management plan

- **resources**

List the resources you will need and ensure you have them ready

- **introduction**

Always begin the tutorial by explaining what you are going to do and why

- **conclusion**

Always end the tutorial by going over the main points

- **evaluation**

Continually evaluate the tutorials. How are they going? Are the objectives being met?

Suggested topics to discuss with registrars in tutorials

Hospital versus community practice

- prescribing
- investigations and costs
- health insurance
- paperwork
- referrals/after hours referrals
- community resources
- home visits/phone consultations
- follow up of patients
- emergencies.

Preventive medicine

- immunisations
- routine check ups
- pap tests
- lifestyle counselling (eg. smoking, physical activity).

Counselling

- personal crises, bereavement
- marriage breakdown
- child behaviour
- aggressive/manipulative/dependent patients
- sexual problems.

Community health problems

- child abuse
- drug and alcohol abuse
- compliance with treatment
- antibiotics for URTIs
- industrial health problems
- sports medicine
- management of chronic pain
- management of the elderly at home.

Minor operations

- ingrown toenail
- skin lesions – excision; cryotherapy; diathermy
- skin biopsy
- IUD insertion
- joint and soft tissue injection
- vasectomy
- fractures; plasters.

Ethics practice management

- appointment systems
- time management
- medical records/filing information
- accounting system
- staff selection and training
- role of staff
- using locum agencies, providing after hours service
- setting up a practice, business structure
- equipment required
- legal requirements and practicing/legal agreements
- obtaining finance
- paperwork
- patient billing.

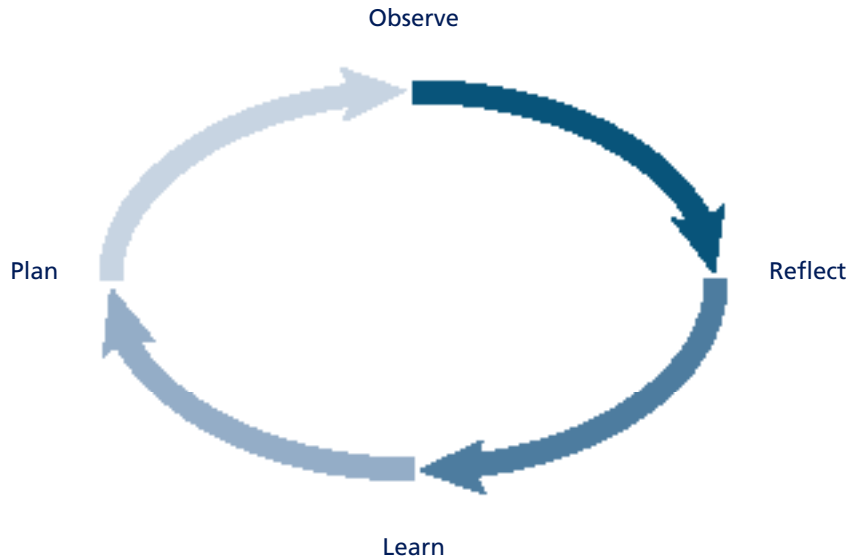
Case discussions

A case discussion is a structured teaching and learning method. This differs from case questions, where a learner asks a question about a patient they have just seen. In case discussions, it may be useful to structure the discussion around the feedback cycle (see next page). Learning is negotiated and the supervisor encourages reflection through questions. Learning is based on actual practice and gives the supervisor an opportunity to discover what the learner is doing in practice.

Advantages	Limitations	Useful for
<ul style="list-style-type: none"> • based on actual practice • allows interchange of ideas • can cover key cases or problem cases • focus on problem solving skills • informs the supervisor about the learner's practice 	<ul style="list-style-type: none"> • potential for learner to be passive • can become outcome focused 	<ul style="list-style-type: none"> • problem solving skills • determining appropriateness of investigation, management • continuity of care • family perspective • community perspective • tolerance for uncertainty • interpretation of data

Strategies for maximising the effectiveness of case discussions

- choose interesting and memorable cases
- encourage active participation
- encourage reflection through the use of searching questions
- follow the feedback cycle in structuring the discussion
- avoid getting locked into content, ensure process is also discussed.



For methods by which a case discussion can be stimulated, refer back to the section on the feedback cycle on page 23.

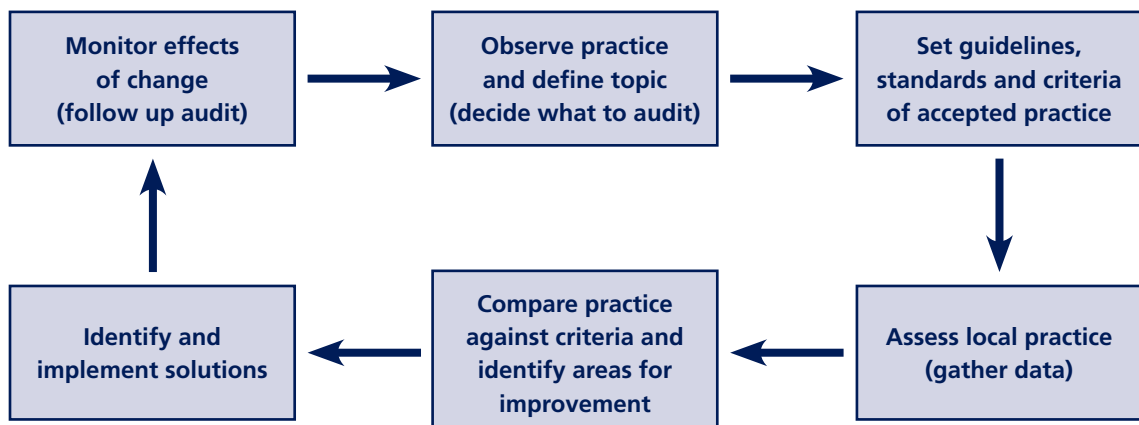
Practice audits

A practice audit compares a picture of actual practice in a certain area with an accepted standard of good practice. As a teaching and learning method, audits are useful for identifying gaps and deficiencies in the learner’s practice, and identifying and implementing solutions.

Advantages	Limitations	Useful for
<ul style="list-style-type: none"> • based on actual practice • encourages reflection • may provide useful information to the practice 	<ul style="list-style-type: none"> • time consuming for learner • some methodological knowledge required • looks at only one area of practice 	<ul style="list-style-type: none"> • organisation of records and reports • data base • family orientation • continuity • preventive orientation • therapeutic choice

Audit process

The audit process can be illustrated as follows:



The full cycle as above incorporates two audits, the second being a follow up audit to monitor the effects of change. While useful, this step is often omitted in a busy general practice. In some audits only the first two steps may be used, eg. an audit of the population breakdown of the practice.

Strategies for a successful practice audit as a learning experience

- keep things simple and limit the scope of the audit
- define the topic well
- choose a topic:
 - that will yield enough data for audit
 - where standards of good practice are readily available
 - where data is easily collected
 - which is amenable to change
 - that is relevant and important.
- collect data that is valid and reliable. For example, if a check list is being used, ticking off items may remind the learner to carry out procedures which may have been omitted without the stimulus. It is questionable how reliable the data is
- ensure data collection techniques are feasible and acceptable to all concerned
- provide feedback to learner. It may be helpful to use the following criterion for assessment:
 - reason for choice of topic
 - criteria chosen
 - preparation and planning
 - interpretation of data
 - detailed proposals for change.

Examples of practice audits

Patients' perception of a general practice registrar's interpersonal skills

Receptionists asked patients to complete a questionnaire about the registrar's interpersonal skills. The registrar graded the consultation as easy, moderate or difficult. Results were collated by a university department and a report sent to the registrar. After the registrar had identified areas of improvements and had developed strategies, a follow up audit was conducted.

Chart review of screening for hypertension

Data was collected from charts about the percentage of patients between 40-70 years of age who had been screened for hypertension. Standard was set at 90% of patients seen within last 12 months. The audit found that only 62% of patients had their B/P checked in the previous 12 months. Solution was to ensure patients B/P was taken. Follow up audit showed 87% of patients had had a B/P check within the previous 12 months.

Example of data collection form

Case no	Patient's name	Age	Sex	Consulted? (Y/N)	BP measured? (Y/N)
1	Joe Brown	45	M	Y	Y
2	Mary Smith	63	F	N	N
3	Mark James	57	M	Y	N
	etc				

Chart review of diabetics

Data was collected from patient charts about the percentage of diabetics who had both eyes and feet checks completed in the previous 12 months. The standard was set at 80% of all diabetics would have had checks completed within previous 12 months. The audit found that only 42% of diabetics had checks. Solution was to ensure checks were completed. Follow up audit showed 87% of diabetics had checks completed.

Antibiotic choice

For a week a GP noted what antibiotics he had prescribed, and for what reason. He compared this data with data on recommended antibiotic treatment, and made changes in his prescribing that he considered worthwhile.

Preventative and lifestyle education

A general practice registrar audiotaped 16 consecutive consultations. At review later she noted when she hadn't included education on preventative and lifestyle issues. She discussed the data with her GP supervisor and identified areas of improvements.

Level of consultations

From practice a GP counted the number of consultations at different levels (Medicare) for the previous 3 months. He discussed the results with a colleague and determined he was within appropriate guidelines.

Example of data collection form

A Level	B Level	C Level	D Level	Total

Summary

Practice audits are useful as a learning method in identifying gaps and deficiencies in the learner's practice and identifying and implementing solutions. Audits are based on actual practice, will encourage reflection and may provide useful information to the practice. For a valuable learning experience, ensure the audit is uncomplicated, relevant and important, and provide feedback to the learner.

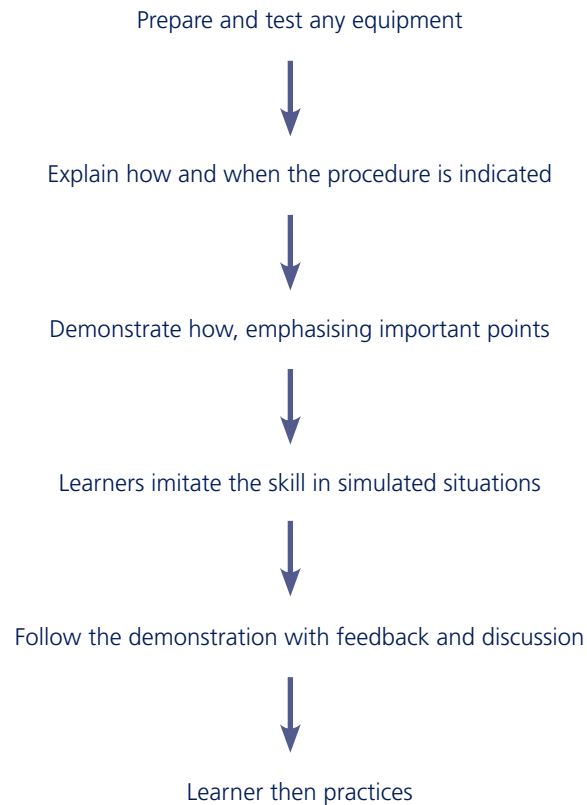
Demonstrations

Demonstrations are effective ways of providing instruction for practical procedures or skills such as consulting, interviewing or counselling. A demonstration is an active teaching and learning method that allows learners to practice without the cost of wrong decisions or actions. By observing the strengths and weaknesses of various demonstrations it is possible to determine the process to creating a successful demonstration.

Advantages	Limitations
<ul style="list-style-type: none"> • learner may participate and learn by doing • allows immediate feedback and discussion • can relate to real practice situation 	<ul style="list-style-type: none"> • expensive in terms of time and resources

The old adage 'see one, do one, teach one' is useful in that it minimises the complexity of learning a new skill. However in reality it may be 'see one, fail at one, teach one'. To avoid this several additional steps are recommended.

Process to a successful demonstration



Strategies for maximising the effectiveness of demonstrations

- ensure the intended outcome relates to the learning objectives, and is clear to the learner
- prepare and test any equipment
- follow the demonstration with feedback and discussion session to alleviate any concerns or problems experienced by the learner, and to highlight the main points to be learned from the exercise.

Role plays and simulations

Role playing is a method where people temporarily adopt a specific role and behave in ways characteristic of that role in a specific situation. For example, a supervisor may role play a drug seeking client who is new to the practice.

In simulations the learner is placed in a setting that imitates reality, such as simulating a doctor-patient consultation in a general practice setting, or simulating a cardiac arrest in the waiting room.

While there is some overlapping of these methods, with simulations often including some role playing, simulations tend to be more complex with more attention paid to the surroundings and props. Both role plays and simulations are active and creative teaching methods that can add significantly to teaching and learning in a general practice.

Role plays and simulations: what is their use?

Role plays and simulations allow real life situations to be acted out in a protected or risk free environment. The learner practices different behaviours, and learns from 'doing' rather than from 'telling', without risk to a patient. Short role plays may also be used to provide a focus for discussion or illustrate a particular point.

These methods are appropriate for some procedural skills, and the 'art' of general practice – consulting, interviewing, counselling, and handling difficult patients. They may also be used to facilitate attitudinal change in the learner, such as enhancing tolerance or sensitivity.

Advantages	Limitations
<ul style="list-style-type: none"> • acts out real life situation in a protected or risk free environment • learner may learn from mistakes without harming the patient • allow provision of immediate feedback, discussion and chance for reflection • learner is active rather than passive • time spans can be compressed 	<ul style="list-style-type: none"> • learner and/or supervisor may feel uncomfortable if unfamiliar with method

Introducing role plays and simulations in teaching and learning in a general practice

A role play or a short simulation does not have to be a complex or time consuming activity. It may take only 1–2 minutes, with no preparation necessary. However, there are times where a well prepared simulation is a valuable method.

Example 1

You have just observed one of your general practice registrar's consultations. The patient is a woman aged 36 years, a regular to the practice, and presents complaining of a cold for a few days and requesting antibiotics. After taking a history the registrar explains to the patient that it's probably viral and she does not need antibiotics. When the patient leaves you notice she does not appear happy.

During debriefing the registrar expresses frustration at patients expecting antibiotics for viral conditions, and uncertainty with how to deal with this situation. You discuss the role of negotiation, suggesting that the registrar repeat the last part of the consultation with you role playing the patient.

Example 2

A medical student suggests he would like to know more about what to do in an emergency situation, eg. cardiac arrest in the waiting room. You decide all the staff could do with an update and arrange a lunchtime when all can be involved. You write out a brief scenario and arrange to borrow a resuscitation mannequin from your local general practice division. Each participant acts out their own role. You repeat the simulation several times before everyone feels competent in their role.

Strategies for maximising the effectiveness of role plays and simulations

- have a clear objective in mind
- ensure the learner clearly understands the objective of the activity and what is expected of him or her
- if preparation is necessary, ensure it is done properly
- if planning to run a simulation, write down a scenario
- debrief at the end of the activity
- repeat the activity if necessary.

Summary

Role plays and simulations are creative methods that allow real life situations to be acted out in a protected or risk free environment. Both methods require active involvement of the learner and are especially appropriate for procedural skills, the 'art' of general practice and facilitating an attitudinal

Suggested practice library

The following are resources suggested for inclusion in a practice library. Many journals and texts are now available electronically through the RACGP resource centre.

- basic texts on medicine, surgery, paediatrics, ophthalmology, orthopaedics, ENT, dermatology, gynaecology. For example:

- Braunwald E (Ed). *Harrison's principles of internal medicine*. Oxford: OUP, 2000
- Ledingham J, Warrell D. *Concise Oxford textbook of medicine*. Oxford: OUP, 2000
- Behrman RE, Kliegman RM, Jenson HB. *Nelson textbook of paediatrics*. Philadelphia: Saunders, c2000
- Adams JC. *Outline of fractures including joint injuries*. Edinburgh: Churchill Livingstone, 1999
- Guillebaud J. *Contraception today: a pocketbook for general practitioners*. London: Martin Dunitz, 2000
- Brown JS. *Minor surgery: a text and atlas*. London: Arnold, 2000
- Pfenninger J, Fowler G. *Procedures for primary care physicians*. St Louis: Mosby, c 2003.
- patient information leaflets
- access to evidence based medicine, eg. Cochrane library via www.thecochrane library.com, BMJ Publishing Group via bmj.bmjournals.com
- colour atlases of skin, eyes
- regular updates of information in textbooks, eg. *Current medical diagnosis and treatment or Medicine journal*
- emergency care handbook
- general practice journals – the most recent 12 issues, plus a collection of articles you think would be useful references for the general practice registrar.
- *MIMS annual*
- *Therapeutic guidelines* series, published by Therapeutic Guidelines Ltd, Melbourne
- significant general practice books, for example:
 - Stewart M. *Patient centred medicine: transforming the clinical method*. Thousand Oaks: Sage Publications, 2003
 - Balint M. *The doctor, his patient and the illness*. London: Pitman, 1964
 - Byrne PS, Barrie EL. *Doctors talking to patients: a study of the verbal behaviour of general practitioners consulting in their surgeries*. London: Royal College of General Practitioners, 1989
 - Pendleton D. *The consultation: an approach to learning and teaching*. Oxford: OUP, 1994
 - Fry J, Sandler G. *Common diseases*. Lancaster: MTP, 1993
 - Hodgkin K. *Towards earlier diagnosis*. New York: Churchill Livingstone, 1985
 - Harris DR, Ramsay AR. *Health care counselling: a behavioural approach*. Williams and Wikins and Ass., 1988
 - Neighbour R. *The inner consultation: how to develop an effective and intuitive consulting style*. Radcliffe Medical Press, 2004
 - McWhinney IR. *A textbook of family medicine*. Oxford: OUP, 1997
 - Murtagh J. *Practice tips*. North Ryde: McGraw-Hill, 2004
 - Murtagh J. *General practice*. North Ryde: McGraw-Hill, 2003
 - Whitman N. *Creative medical teaching*. University of Utah School of Medicine, 1990
 - Whitman N, Schwenk T. *The physician as teacher*. Utah: Whitman Associates, 1997
 - RACGP training program. *The core curriculum*. Melbourne: RACGP, 1997
 - RACGP training program. *Making sense of gplearning: companion to the training program curriculum*. Melbourne: RACGP, 1999.
- titles in the *Oxford general practice* series, published by OUP, are also recommended resources. The series includes books on paediatrics, geriatrics, preventive medicine, women's problems and locomotor disability.

Resource materials

This manual has listed a number of useful resources.

The RACGP curriculum and RACGP curriculum companion are available on the college website, www.racgp.org.au.

Check the website for holdings and services of the RACGP resource centre. As well as books and journals, the centre has many electronic materials available.

gplearning is the college's online learning system. It contains a wide range of interactive learning resources.

Contact your regional training provider for details of local resources.

Helping your registrar prepare for the RACGP examination

The RACGP exam is the end point of training for general practice registrars. They usually sit for the exam during their last year of training. The exam is held twice per year.

After passing the exam and successfully completing training, they are eligible for fellowship of the college, and vocational registration in their own right. Full details on the requirements for fellowship may be found on the RACGP website.

There are three components in the exam – an applied knowledge test (multiple choice), key features problems (extended choice cases), and the clinical examination. The first two are written exams and are undertaken together on a single day. The clinical exam is usually held about a month after the written exams. It consists of 17 stations. These assess history taking, communication skills, physical examination and procedural skills, patient education, preventive care, diagnostic skills and more.

General practice trainers can assist registrars to prepare for the exam, particularly by encouraging them to develop sound clinical skills and directing them to other resources.

Strategies for personal preparation

There is considerable evidence in the literature that assessment motivates learning. The first question a potential candidate should consider is, 'What is Australian general practice?'. The answer to this question will provide insight into the knowledge, skills and attitudes that are relevant to everyday practice, and therefore the examination.

The domains of general practice that form the basis for teaching in the RACGP training program are the same as those used when compiling the college examination. The frequency and patterns of problems as they present to general practice should also be considered during exam preparation.

In approaching any examination it is important to understand not only the examination format, but the objectives of each of the assessments. By better understanding what is being assessed in each segment, preparation (and actual practice) can be directed along these lines. Reviewing the rating forms that will be used in the assessments provides valuable insight into what is required, and the semantic differentials used will give information on the level of performance required.

Training for general practice occurs in the work setting, not in a library. Similarly, preparation for an examination of general practice should occur in the practice setting. The examination does not solely assess book knowledge, it aims to assess how knowledge is applied in everyday situations involving patient care. The actual processes of patient care and doctors' attitudes are also important aspects of the RACGP examination.

Although many candidates form study groups to support each other and practise various examination segments, one of the most valuable preparations is reflective general practice. This can be done during and after actual patient consultations in everyday work. Reflect and self assess your performance with each patient seen during a day's consulting. Ask questions of yourself. How well did I listen? Did I obtain sufficient history from the patient? Did I perform a relevant and accurate physical examination? Did the patient understand my management plan? Did I allow the patient to be involved in their own management? Were there any preventive issues I should have considered? What family and community resources would help me in managing

this patient better?

By honestly answering these and many more questions, candidates become more aware of their own performance in general practice and can change any aspect as they consider appropriate. By performing well in actual practice it becomes easier to translate these behaviours into the examination situations. After all, the examination is trying to determine what it is the candidate does in practice.

Available resources

There are practice papers in the exam handbook that allow candidates to familiarise themselves with the format of the papers and the style of questions. The questions are selected from the actual examination banks, (however, for security reasons these questions have now been removed from the active banks and will not appear in any future examination papers).

These papers are not meant to be a comprehensive study aid, but rather give guidance on the type of questions asked and some examples showing the level of knowledge required. Some resources previous candidates have found useful in examination preparation are:

- *The RACGP college examination handbook*
- *Australian Family Physician* (RACGP publication)
- *CHECKUP* (RACGP publication)
- *Check on **check*** (RACGP publication)
- Murtagh J. *General practice*. North Ryde: McGraw Hill, 2003
- clinical atlases (eg. dermatology, radiology, ECGs)*
- videos of clinical procedures and physical examination techniques.

The resources indicated (*) may be purchased at your local medical book suppliers. They are also available for limited loan through the RACGP resource centre, as well as undergraduate and postgraduate libraries. The text *General practice* by John Murtagh is recommended not only for study – it is also a useful reference in your surgery and may be worthwhile purchasing.

Your role in assisting your registrar to prepare for the college exam

Your daily teaching and supervision of the registrar in the practice is the best training for them for general practice, and consequently for the college examination, which is an assessment for competent unsupervised general practice.

Within your teaching, you may be interested in incorporating more specific examination preparation material. The supervisor is better placed to assist in preparation of clinical segments of the exam (patient consultations, management interviews, physical examination and general practice orals) and in the clinical interpretation paper.

- encourage the registrar to reflect and self assess their performance and knowledge with each patient seen in a day's consulting
- encourage them to videotape their own consultations and review it with them, reflecting on improvement in communication style, history, examination, logical problem solving skills, patient education, formulations of a management plan and incorporation of preventive issues and community and family resources
- encourage them to attend the pre-examination course, which outlines exam details and provides opportunities for practice
- encourage them to join a study group
- help them develop a learning plan from their identified weaker areas and assist them in achieving this plan, reviewing it at regular intervals
- familiarise yourself with the current examination format and direct the registrar to also become familiar with its demands and accommodations.

