ERG023 MCCC – Supervision of high risk early consultations in GP training

Aims and Objectives

Our research focussed on safety in early GP training. A registrar at the start of GP training in Australia can see patients only being required to call their supervisor when the registrar considers it necessary. The RACGP Standards for Training require a registrar only manages a patient they are competent to manage but these are outcome standards and no detail about how this outcome is to be achieved is provided. In contrast, an international medical graduate commencing general practice in Australia is likely to be advised that they must call their supervisor about every patient they attend before the patient leaves the building. A previous ERG study found that the level of supervision at the start of GP training is less in Australian than in other comparable international GP training programs.

Our research sought to answer three research questions about safety in early GP training. How are Regional Training Organisations (RTOs) achieving the standard that registrars only manage patients they are competent to manage? What are the circumstances in GP training where closer supervision is required and how could this be achieved? What are the views of registrars, supervisors and medical educators on a period of closer supervision at the start of GP training?

Methods

There were three phases of the research project corresponding to the research questions. All involved qualitative methods. In the first phase semi-structured interviews about safety in early GP training were conducted with a lead medical educator from each of the nine RTOs. The responses underwent inductive content analysis.

For the second question action research methods were used. The researchers involved seven focus groups of supervisors and registrars to determine the circumstances where a registrar should seek supervision and how this could be best achieved in practice.

The interviewed lead medical educators in the first phase and the registrar and supervisor focus group participants in the second phase were questioned about a period of closer supervision at the start of Australian GP training. Their responses underwent inductive content analysis.

Results

From the interviews of lead medical educators our research found that RTOs do not mandate a period of direct observation of trainees at the start of training. The use of safety checklists for supervision is variable across the country and is not routinely monitored. RTOs delegate to practices the responsibility of ensuring the registrar only manages patients they are competent to manage and do not confirm this is occurring.

Other factors found potentially impacting on safety include the acknowledged variability of training practices and supervision. The current funding model provides an incentive for the registrar to see more patients. A focus on service delivery over education could jeopardise patient safety. There are concerns that the requirement on RTOs to fill a quota of GP training places may result in the inappropriate selection of some junior doctors into GP training. The requirement that 50% of training must occur in rural practices may provide a disincentive to RTOs to remove poorly performing rural practices. Despite these concerns for registrar patient safety, lead medical educators still consider the commencement of general practice training to be safe.

The focus groups developed a ‘call for help’ checklist for use at the start of GP training. They identified 80 circumstances where a GP registrar should call their supervisor. Most of the items on the list are identifiable clinical situations but some are broad indications of registrar uncertainty we termed ‘uncertainty flags’. The clinical situations on the list were included on the list because they were either: high-risk situations for all GPs, new problems the registrar was unlikely to have encountered previously, or problems the registrar may have seen previously where the presentation or management is different in a general practice context.

The list should be the supervisor’s responsibility to monitor and adjust, but the registrar’s responsibility to maintain. The registrar should call their supervisor for each item on the list until the supervisor determines

that this is no longer necessary. The assessment that a registrar is no longer expected to seek supervision for an item on the list is made by their supervisor. This would either be through supervision of registrar clinical work, or by the issue being satisfactorily covered during an in-practice teaching session. It is likely that many items will remain on the list throughout the term, particularly those considered high risk for all GPs.

The supervisors and registrars were keen to avoid what they consider unnecessary administrative or assessment burden in using the list. They did not consider that the justification for removing an item from the list needed to be recorded.

The final phase of the research found registrars are strongly supportive of change to closer supervision. Supervisors and medical educators are generally supportive of change, but a small number believe there are not safety problems in the current system and see no need for change. Those who are ambivalent about a change to closer supervision are accepting of a change if it is appropriately funded and there is workforce capacity.

A process in early GP training of the registrar progressing through levels of supervision was proposed. Progression would be based on an assessment of competency that involves an assessor external to the practice. A registrar would commence training with all consultations observed before progressing to wave consulting where the supervisor checks in on the registrar's management at the end of the consultation. In the next stage, a supervisor would review the registrar's notes with the registrar at the end of each day. The final stage would allow the registrar to determine when help is needed which is the current supervision level in Australian GP training. This final stage may be aided by the use of the 'call for help' list to ensure the registrar calls when appropriate. The progression through the stages of supervision is expected to take between one to three months.

Discussion and Implications

We have uncovered concerns about the safety of early GP training in Australia. Although the lead medical educators consider training to be safe, this was hard to reconcile with the observation that patient safety is delegated to practices of acknowledged variable quality. In this respect, the oversight of training practices by RTOs mirrors that of registrars by supervisors. The onus falls on those being supervised to identify the need for assistance.

In examining the possibility of a change to closer supervision at the start of training we found that there is broad support for such a change if there is appropriate funding and a supervisor workforce capable of delivering it. We have proposed a new model for the safer commencement of GP training that involves an initial period of closer supervision. In response to the registrar's competence a registrar would progress from all consultations being observed, through record review to the registrar determining when help is needed. Only one to three months may be required to achieve this transition meaning the extra cost of closer supervision may be less than initially contemplated.

Our 'call for help' list provides a co-designed process for registrars to use when they are responsible for determining when to call their supervisor. At a time when programmatic assessment is being adopted in GP training, our participants rejected the burden of being required to record the justification for their decisions. They wanted an aid to supervision rather than an assessment tool. In effect they rejected the use of the list as an entrustable professional activity assessment.

The 'call for help' list should be an aid to communication between registrar and supervisor, particularly about the registrar's current competence and the supervisor's willingness to help. It can be implemented in the current training model but could also have a place in a redesigned training program that included closer supervision at the start of GP training.

Future Research

We identified the need for further research into the safety of early GP training. Pilot studies into the proposed model of closer supervision at the start of GP training and the use of the 'call for help' list are indicated. Educators and supervisors resistant to a period of closer supervision at the start of GP training wondered if there was evidence that registrars are less safe in their practice than fellowed GPs? Currently

there is not an agreed method to measure the quality or safety of general practice in Australia, but were this to be devised, it would be possible to measure the relative safety of registrars and fellowed GPs.