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Registrar Clinical Encounters in Training (ReCEnT) Project

Interpreting the Practice Feedback Report – A Guide for Supervisors and Practice Managers

Background

Clinical encounters are the core learning activity of general practice training in Australia. Ideally, the content of each registrar's clinical experience should include "common and significant conditions" and be similar to that of established Australian GPs.

However, in real life, the curriculum "walks through the door", and the exposure to different patient demographics and presentations can be highly variable between training practices and from one registrar to another. This can have an impact on the nature and quality of training.

The ReCEnT project aims to document and analyse the nature of the clinical and educational content of general practice registrar consultations. Every GP training term, registrars record details of sixty consecutive consultations. Practices that have hosted at least five ReCEnT 'registrar-rounds' (i.e. a total of five terms spent in your practice by registrars who have participated in ReCEnT) are sent a feedback report annually which compares their registrars' cumulative, de-identified patient encounter data to aggregated data of all registrars who have participated in ReCEnT. For some outcomes, comparison is also made to national GP clinical activity data.

Supervisors and practice managers are encouraged to reflect on the information in the report in terms of their registrars' clinical exposure, test ordering practice, prescribing, and seeking of information. This guide is designed to assist supervisors and practice managers in reviewing the Practice Feedback Report.

Using the ReCEnT Practice Feedback Report is *not* a benchmarking exercise. It is designed to prompt *reflection*. If a practice's ReCEnT results on any parameter in the report are different to comparator data, this should prompt reflection of what might have influenced the result, what it means, and whether it needs to be addressed in any way. It does not mean that your practice is a 'poor' place for a registrar to learn. For example, a practice report may suggest that registrars at your practice seek their supervisors' help during consultations considerably less often than the average for all practices. This could lead you to consider the demographics of the registrars in your practice (e.g. early term registrars seek help considerably more than later term registrars). It may also lead you to reflect on supervisory and information-provision structures in your practice (e.g. supervisor availability and approachability; mechanisms to discuss non-urgent clinical queries at the end of a session rather than in-consultation; levels of registrars' access to, and training in, information-seeking via guidelines or clinical resources).

Thus, reflection on results in the report should encompass critical appraisal of the results.

Critical Appraisal

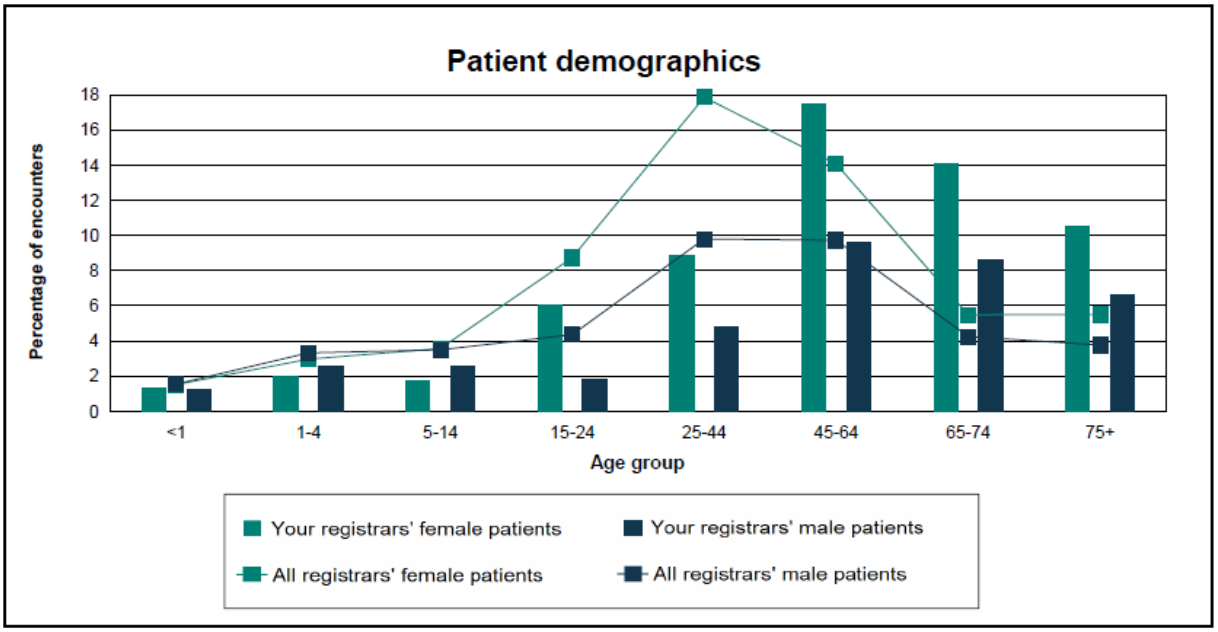
Interpretation of this report requires consideration of a number of factors which may affect the results. We therefore encourage you to critically appraise the results. For example:

- Were the ReCEnT participating registrars in your practice 'typical'? That is, were the demographics roughly comparable with other practices? For example, proportion in first versus later terms; proportion male/female; proportion of overseas-trained registrars; proportion part-time.
- How much of a particular result might have been due to the practice demographics? For example, large versus small practice; rurality of the practice; socioeconomic status of the practice; age distribution of the practice population.
- How might organizational processes within the practice have contributed to the findings? For example, a rural practice might have a process of assessing and managing some presentations at the local GP-run hospital (these consultations would not appear in the ReCEnT data).

Specific Components of the Feedback Report

The Patients

Consider the proportion of male and female patients your registrars saw compared to their peers, and how the mean age of patients compares. Review the graph to see if particular age groups and genders were under or over-represented. How does this compare to your practice demographics? Is there any way of addressing a demographic imbalance in your registrars' experiences?



For example, the graph above shows that the registrars of one practice have clearly been seeing mainly older patients, and possibly have reduced exposure to clinical problems related to children and younger adults.

Are your registrars' patient exposures comprehensive, or is there a deficit in any particular demographic?

Aboriginal/Torres Strait Islander patients

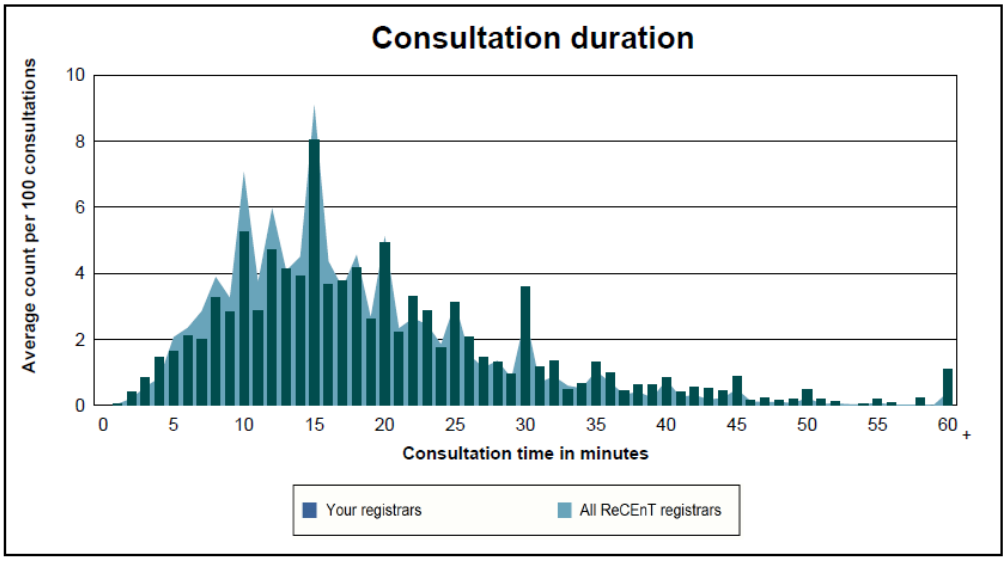
Aboriginal Australians have a substantially greater burden of illness than their non-Aboriginal counterparts. Identifying Indigenous status is an important element of the consultation. The feedback report identifies the percentage of patients who were identified as Aboriginal or Torres Strait Islander. Does this number reflect your practice profile?

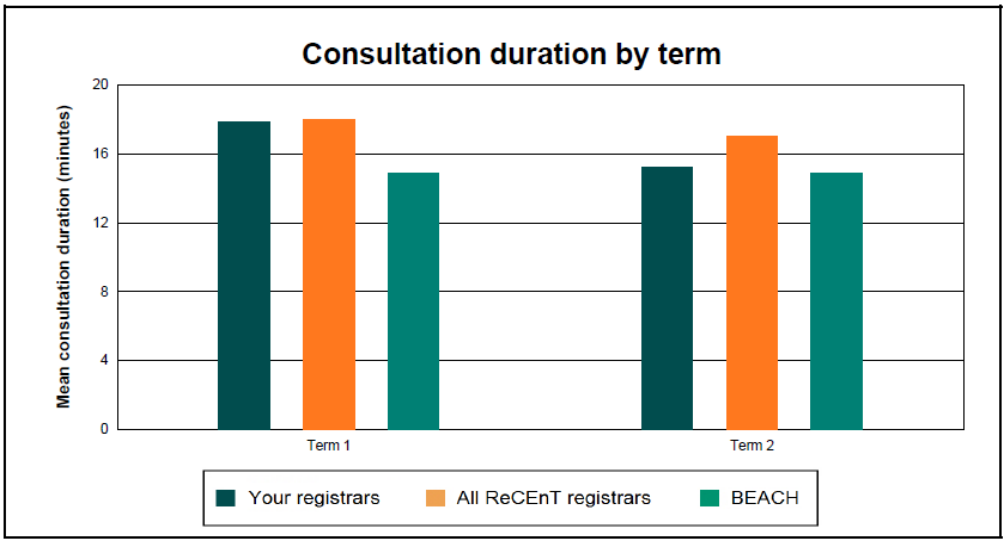
Non-English Speaking Background (NESB) patients

Patients from some culturally and linguistically diverse backgrounds are at higher risk of poorer health outcomes than other groups of Australians. In part, due to barriers such as language, health literacy and lack of familiarity with the health system. The feedback report estimates the proportion of these patients using the marker of non-English speaking background. How does this number compare to your practice profile? And how may that affect your registrars' learning experiences?

Duration of Consultation

The duration of the consultation is an important feature of quality of care in general practice. Longer consultations are associated with a number of factors - higher patient satisfaction, opportunistic preventive care, and identification and management of psychosocial problems.





Consider the mean duration of consultation of your registrars, and the distribution of their consultation duration times, compared to their peers.

Continuity of Care

Continuity of care has been found to be closely related to patient and doctor satisfaction and to positive clinical outcomes. Registrars record whether they have seen the patient before, so called 'upstream continuity'. Compare your registrars' new patient rate with that of all ReCEnT registrars and other GPs in your practice. Is this expected? Do you think it might have any impact on their training? Is there scope in your practice to increase registrars' exposure to continuity of care?

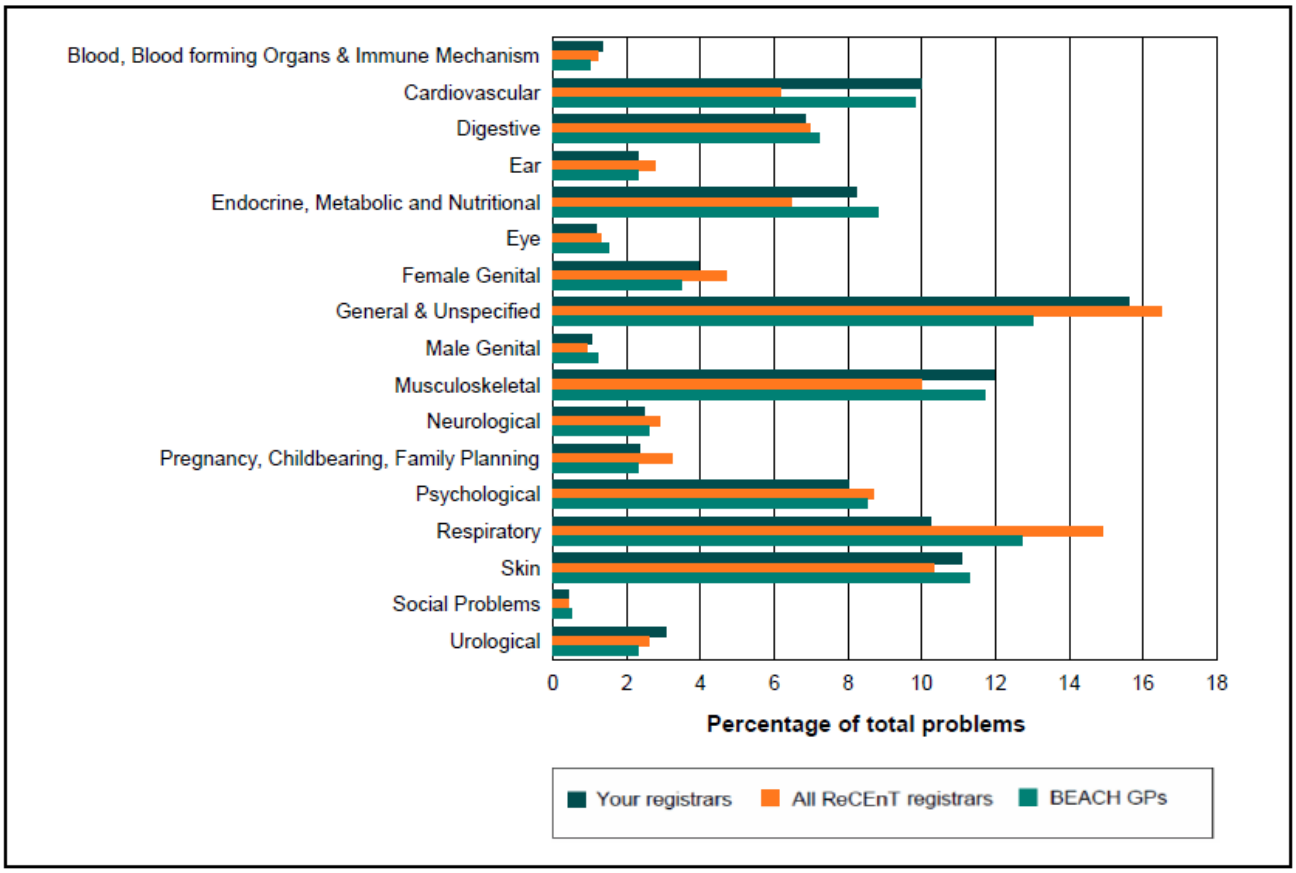
Problems Managed

'Problem managed' is defined as the 'single most likely provisional diagnosis'. Registrars are asked to record at least one, and up to four, problems.

Registrars manage about 150 problems per 100 encounters, or about 1.5 problems per consultation, on average. This is almost exactly the same as BEACH data. See how many problems your registrars are managing, and the nature of these problems from the graph. Are there any substantial differences from their peers?

Consider the case-mix of your registrars' ReCEnT consultations. Does it relate to the proportion of male/female registrars who have participated in ReCEnT in your practice or the gender and age mix of their patients? Is it a surprise? How might the practice address potential gaps in clinical exposure?

For example, the following graph of problems managed reveals that this particular practice's registrars see almost twice the number of cardiovascular problems (e.g. hypertension, IHD, heart failure) than the average for their peers in other practices. They also have higher rates of endocrine (e.g. diabetes) problems. This would be consistent with older patients with more chronic disease. Does your report's graph reflect your practice profile?



General and Unspecified Problems

The General and Unspecified Problems 'disease chapter' in the problems managed graph above encompasses non-specific medical problems e.g. prescriptions not attributed to a specific diagnosis/problem, viral illness, medical examinations etc., but also immunisations.

Observations and examinations

It's important that registrars gain experience in conducting physical examinations in the general practice setting and adapting their physical examinations to the general practice consultation context. Do your registrars seem to be having adequate opportunity to conduct physical examination?

Pathology and Imaging

Registrars find pathology and imaging test ordering a challenging area of practice, with some evidence to suggest that tests are not infrequently inappropriately ordered. Have a look at your registrars' pathology and imaging test ordering, in particular the proportion of encounters where a test is ordered (in the text), and the rate per 100 encounters (shown in the graphs). How does this compare to their peers, and to BEACH data? If above the mean, does this reflect appropriate test ordering in the context of older patients with more chronic disease, for example, or does it reflect anxiety and fear of missing serious illness?

Perhaps go back to the problems managed graph and see if this might explain the rates of test ordering e.g. lots of antenatal patients lead to large numbers of tests ordered, or a preponderance of simple acute respiratory infective illnesses might lead to relatively few tests.

Prescribing

There is also evidence that GP registrars find prescribing complex, and the transition from hospital to community setting difficult. The GP supervisor has been found to play a significant role in influencing registrar prescribing practice.

'Medications prescribed' includes OTC medications as well as prescribed drugs. Consider at your registrars' new prescription ordering rates compared to the group. What factors may be influencing prescribing rates of new medications? Again, consider at the number and nature of problems managed, especially new problems and chronic diseases. Are your registrars simply writing lots of repeat prescriptions, or are they initiating new drugs?

Deprescribing

As with prescribing, the science and art of deprescribing need to be developed and refined by registrars. Deprescribing is especially important in older patients with multimorbidity and polypharmacy, and there is evidence that registrars find deprescribing difficult and require considerable supervisor guidance and oversight when deprescribing for older patients. Reflect on deprescribing rates in your practice and what structures are in place, or could be implemented, to support registrars' rational deprescribing.

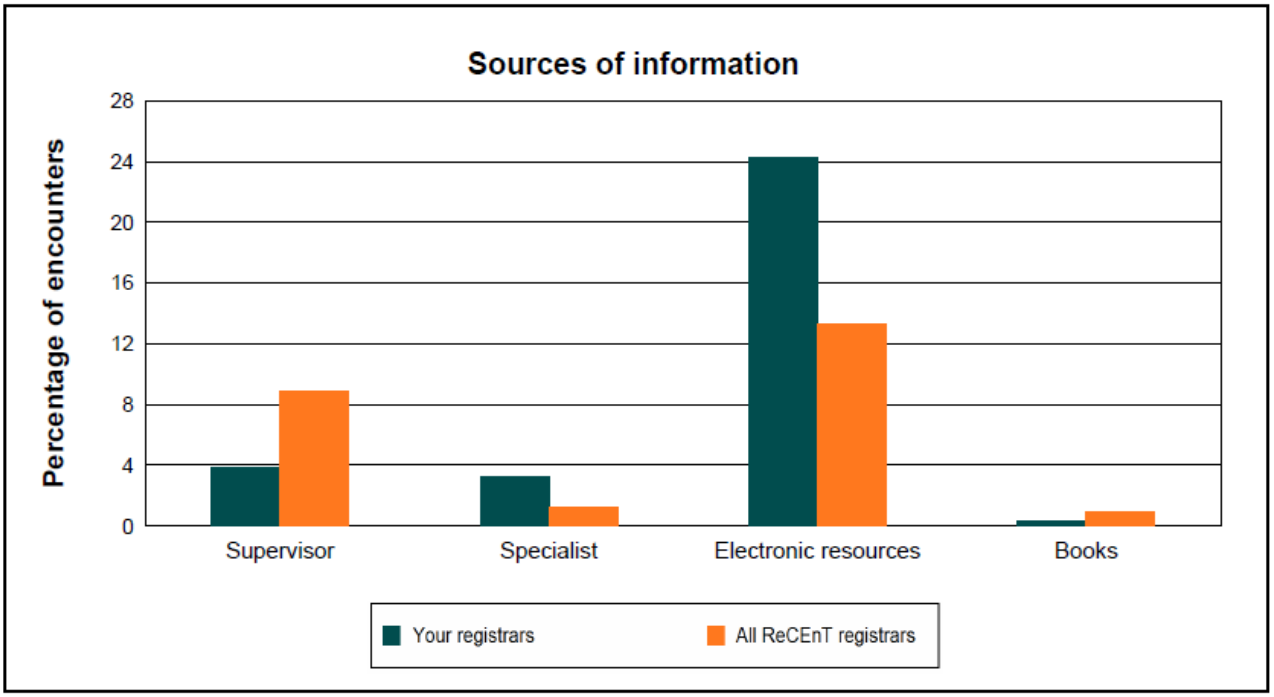
Referral

Overall, registrars refer patients to specialists at a rate of ~ 50% more than established GPs. Consider at the rate of referral for your registrars compared to their peers. Are there aspects of your practice's patient demographics or organizational or clinical approaches that might influence your registrars' approaches to specialist referral?

Sources of Information

Registrars were asked to identify whether they sought information or assistance during the consultation for either diagnosis or management. Overall, registrars access some source of within-consultation information in about one fifth of consultations. The principal sources of in-consultation information are the supervisor and electronic sources. Consulting the supervisor for advice reduces with increasing level of seniority of the registrar.

Consider at the rates of information seeking for your registrars. How do they differ from their peers? Are the registrars accessing electronic resources? Which ones? Are they calling specialists for advice?



For example, the graph above shows that registrars at one practice consulted their supervisor less than the average rate for all ReCEnT registrars, but consulted all other resources at higher rates than did their peers. Does this reflect seniority of their ReCEnT-participating registrars, an issue discussing cases with their supervisors, relative inaccessibility of supervisors, organizational aspects of ad hoc teaching within the practice, or some other identifiable factor?

Learning goals

Consider your registrars' most common learning goals generated during consultations. Are there areas that you feel would warrant addressing in dedicated practice teaching sessions or in ad hoc teaching opportunities?

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