RACGP

ReCEnT
Registrar Clinical Encounters in Training

Interpreting the Registrar Feedback Report

A guide for supervisors and medical educators

Contents

Background

Clinical encounters are the core learning activity of general practice training in Australia. Ideally, registrars should gain experience managing common and significant conditions encountered in everyday Australian general practice. However, clinical exposure varies between practices and registrars, meaning learning experiences can differ considerably.

The ReCEnT project documents and analyses the clinical and educational content of registrar consultations. Each training term, registrars record details of 60 consecutive consultations and receive a feedback report comparing their de-identified data with aggregated registrar data and, in some cases, national GP activity data.

The purpose of the report is to support reflection on areas such as clinical exposure, prescribing, test ordering, follow-up, and information-seeking behaviours. Supervisors and medical educators are encouraged to use the report as a basis for discussion, exploring the factors behind the findings and the learning opportunities they may present.

Importantly, the ReCEnT report is **not a benchmarking or performance assessment tool**. Differences from peer averages do not necessarily indicate a problem. Rather, they should prompt reflection on the factors that may have influenced the result, what it means in the registrar's context, and whether any further learning or exploration is warranted.

Critical appraisal

When interpreting the report, consider the context in which the data were collected. Discussion questions may include:

- Were the 60 consultations representative of the registrar's usual practice?
- How might the patient population or practice setting have influenced the results?
- To what extent might differences from peer averages reflect the consultation sample rather than usual practice?
- How might the registrar's consulting style, decision-making, or stage of training have influenced the findings?
- What learning opportunities are suggested by the results?

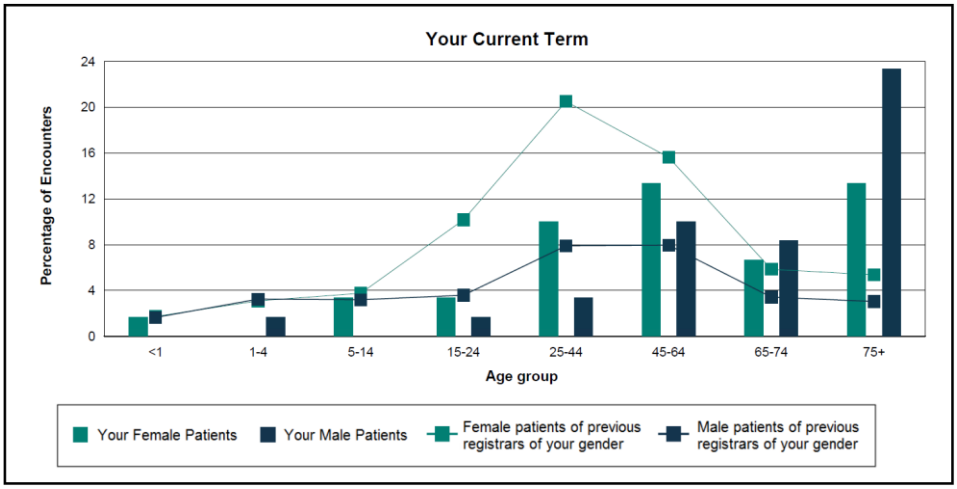
The report is most valuable when used as a tool for critical reflection, discussion, and ongoing professional developmen

Specific components of the feedback report

The patients

Looking at the proportion of male and female patients the registrar saw, consider how this compared with registrars of the same gender. Also, see how the mean age compares. Review the graph to determine whether particular age groups or patient sex categories were under- or over-represented.

How does this compare to your practice demographics, or your own practice? Is there any way of addressing a demographic imbalance in your registrar's experience?



For example, the graph above shows that the registrar was clearly seeing mainly older male patients, and likely to be missing out on a number of clinical problems related to children and female patients.

Also, look at the cumulative data on patient demographics if the registrar is Term 2 or above - is exposure comprehensive, or is there a deficit in any particular demographic?

Aboriginal/Torres Strait Islander patients

The feedback report identifies the number of patients your registrar saw who identified as Aboriginal or Torres Strait Islander.

Aboriginal Australians have a substantially greater burden of illness than their non-Aboriginal counterparts. Identifying Indigenous status is an important element of the consultation. This is an opportunity to ask the registrar about their general approach to identifying Indigenous status of patients, the specific patients and presentations, and whether they felt the patient's Indigenous status influenced their management in any way.

Patients with a non-English speaking background (NESB)

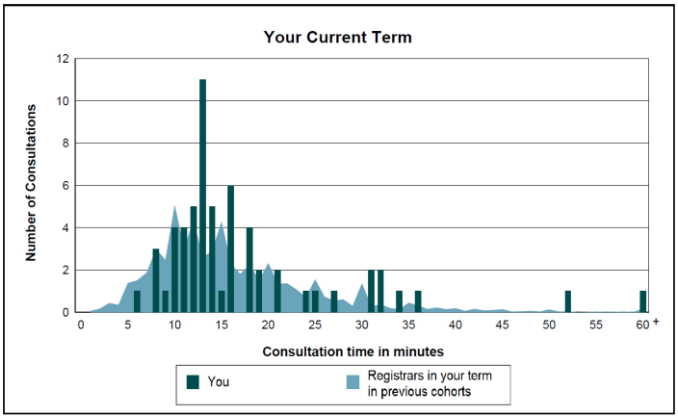
This report also records if any consultations were conducted in another language.

The BEACH program found that one in 10 consultations involved a NESB patient. It also found that the demographics and problems presenting by NESB patients differed from English speaking patients. Is the number of consultations with a NESB patient by your registrar typical for the practice or region? This is an opportunity to ask the registrar about their approaches to NESB patients.

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 including higher patient satisfaction, opportunistic preventive care, and identification and management of psychosocial problems.

Consider the mean duration of consultation of your registrar compared to their peers, and also the spread of consultations. You might ask about any particularly short or long consultations, and how they feel their time management is going.



If the registrar has completed more than one round of data collection, there will be a term-by-term comparison of consultation durations. Ask the registrar about any change in the mean duration of consultation from term to term – does this reflect changes in their capacity for time management?

Continuity of care

Continuity of care is associated with greater patient and doctor satisfaction. ReCEnT captures two aspects of continuity.

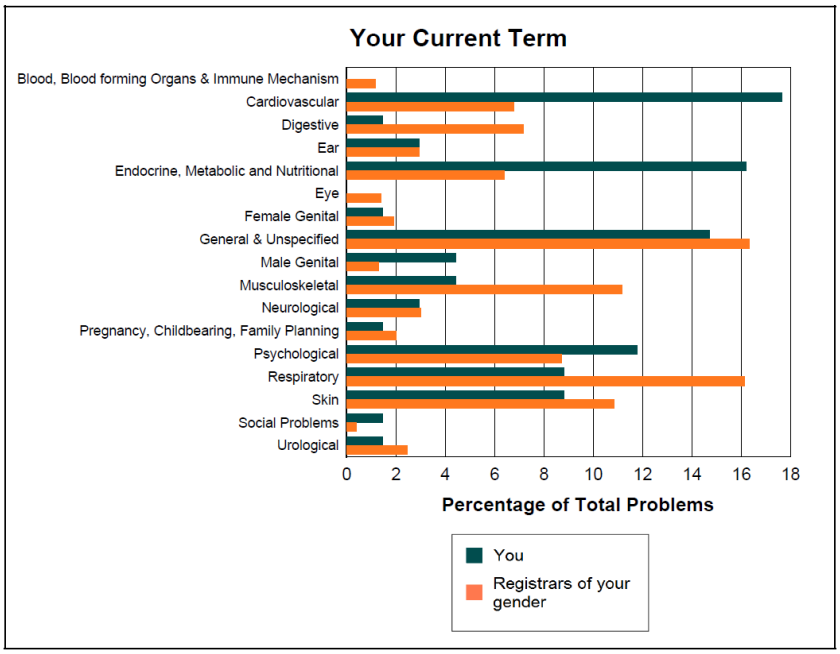
Upstream continuity refers to whether the registrar has seen the patient before. Compare your registrar's rate with that of other registrars and with your own practice patterns. Is this what you would expect, and how might it influence their learning?

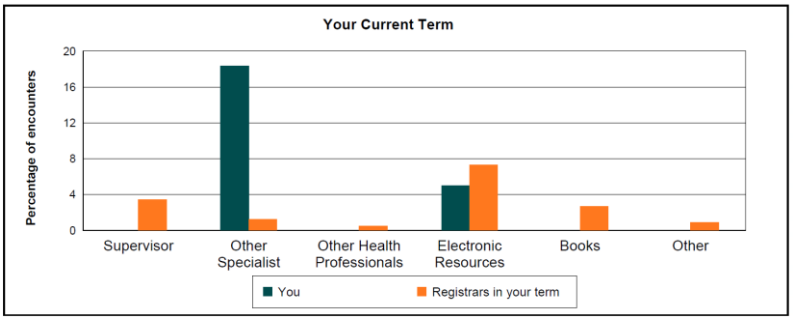
Downstream continuity refers to follow-up arrangements. Compare the registrar's follow-up rate with those of other registrars and your practice. Explore how follow-up is managed, including whether patients are encouraged to return to the same doctor or any available clinician.

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.

Overall, 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 registrar is managing, and the nature of these problems from the graph. Are there any substantial differences from their peers (of the same gender)? Could these differences relate to the age distribution or sex distribution of patients seen? Is it a surprise? How might the practice address gaps in clinical exposure?

Problems managed cont.	 For example, the graph above of problems managed reveals that this particular registrar (the same one as before) sees almost twice the number of cardiovascular problems (eg hypertension, IHD, heart failure) than his peers. He also has higher rates of endocrine (eg diabetes) problems. This would be consistent with older patients with more chronic disease. It might be worth asking how much 'true' management he does, or whether he is just 'baby-sitting' these patients for other doctors in the practice. Again, look at the cumulative data for all previous terms (if available) and discuss any strengths or weaknesses in clinical exposure.
General and unspecified problems	This 'disease chapter' encompasses non-specific medical problems eg prescriptions, viral illness, medical examinations etc., but also immunisations. If the registrar has very high rates of presentations of this category, ask about the nature of problems seen. It might also be worth asking about undifferentiated problems which are difficult to code. These are associated with greater clinical uncertainty and ambiguity, and can lead to anxiety and over-investigation, particularly in the less experienced registrar.
Observations and examinations	It's important that registrars gain experience in conducting physical examinations in the general practice setting, as well as adapting their physical examinations to the general practice consultation context. Did your registrars have adequate opportunity to conduct physical examination?
Top 10 problems	Review the top 10 problems managed by registrars overall. Does the registrar recall seeing these commonly, and were they comfortable managing them?
Pathology and imaging	Registrars find pathology and imaging test ordering a challenging area of practice, with some evidence suggesting that tests are often inappropriately ordered. Have a look at the registrar's 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 eg lots of antenatal patients lead to large numbers of tests ordered, or simple acute illnesses might lead to very few tests. Also, have a look at the top tests ordered by registrars overall and perhaps explore this with the registrar – are they the same common tests, are there difficulties interpreting them etc?

Prescribing	There is 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. Have a look at new prescription ordering rates compared to the group. What factors may be influencing prescribing rates of new medications? Again, have a look at the number and nature of problems managed, especially new problems and chronic diseases. Is the registrar simply writing lots of repeat prescriptions, or are they initiating new drugs? As with tests ordered, have a look at the top 10 prescribed medications ordered by registrars overall and discuss their use with the registrar.
Deprescribing	Deprescribing is increasingly being recognised as an area of importance, especially in the management of multi-morbid patients. Polypharmacy is common in these patients and disease-specific clinical guidelines are not equipped to provide assistance with their management. Consequently, identifying potentially inappropriate medicines is an ongoing task for the GP who typically coordinates the care of these challenging patients. Review whether the registrar deprescribed any medications and discuss the circumstances if they can recall them, or use it for a random case analysis to explore the patient's management. Then look at the top 10 list of medications de-prescribed by all registrars and consider how these may be relevant to the patient base your registrar is seeing.
Referral	Overall, registrars refer patients to specialists at a rate of ~ 50% more than established GPs. Have a look at the rate of referral for your registrar compared to their peers – remember, numbers here are small and may not be representative of usual practice. This is a good opportunity to explore the registrar's approach to specialist referral. The feedback report also identifies the number of patients who were referred to hospital. Perhaps ask the registrar about the patient and presentation (and perhaps review the notes) and explore the clinical reasoning around why they were sent to hospital.
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 the rates of information-seeking for your registrar - how do they differ from the registrar's peers, and how have they changed over time? Is the registrar accessing electronic resources? Which ones? Are they calling specialists for advice? This is a great opportunity to discuss lifelong learning and your own practice around clinical information-seeking.  For example, the graph above refers to the registrar whose data has been presented previously. He did not consult his supervisor during the recording period but calls specialists at a much higher rate than his peers. Does this reflect inaccessibility of his supervisor during the data collection period, a more 'mature' practice by asking specific questions of specialists, or something else? Review the top sources of information-seeking by registrars overall. Are these similar to the sources your registrar reports using? Would you recommend others?

Learning goals	For the purposes of the ReCEnT project, learning goals are defined as 'expected educational outcomes as a result of the clinical encounter'. This does **NOT** include information accessed at the time of the consultation (this should be recorded in **Sources of Information, as above)**. Rather, it refers to plans to look up information or seek advice about following the consultation or at some time in the future. Does your registrar recall having followed through with researching these learning goals? Did they find the process and the information they obtained useful? Have a look at the registrar's learning goals and also at the top 10 learning goals by all registrars and reflect on any similarities or differences.
Follow up	After reviewing the feedback report, it is useful to make a brief summary of the key findings and a plan for addressing any identified gaps in clinical exposure or other educational needs. These can be reviewed again at the end of term as part of the end-of-term feedback session.

If you have any questions, please contact Parker Magin on 0408 953872 or Parker.Magin@racgp.org.au