ReCEnT FAQs

1. What is ReCEnT?

Clinical encounters are the core learning activity of general practice training in Australia. However, exposure to different patient demographics and presentations is highly variable between registrars and practices. This has a clear impact on the nature and quality of training.

The Registrar Clinical Encounters in Training (ReCEnT) project aims to document and analyse the nature of the clinical and educational content of general practice registrar consultations. You will record details of sixty consecutive consultations on three occasions during your training time. Educational factors related to the encounter will be recorded along with clinical consultation details.

The project documents the content and nature of Australian GP registrars' clinical consultations over time. This information is of great value in supporting both your individual learning, as well as informing your education and training program overall. The study also provides a platform for further research and audit activity, including by GP registrars.

2. When did ReCEnT begin?

In the second term of 2009 (the now former) General Practice Training – Valley to Coast (in the Central Coast, Hunter Valley and Manning River areas of NSW) undertook the 'pilot round' of ReCEnT. Full-scale operation of the project commenced in 2010 and other Regional Training Providers (General Practice Training Tasmania, Victorian Metropolitan Alliance, Adelaide to Outback General Practice Training, and Tropical Medical Training) commenced participation between 2011 and 2014. With the change in GP vocational training in 2016, ReCEnT was conducted in the Regional Training Organisations GP Synergy (NSW and ACT), General Practice Training Tasmania and Eastern Victoria General Practice Training. With the move to profession led training in 2023, ReCEnT is now conducted by RACGP.

3. What is the point of completing ReCEnT? How will it help my training? How will it promote better patient care? How will it make us better doctors?

The educational point of ReCEnT is to give you insight into your own practice via a process of reflection. It can allow you to identify areas where you are not getting enough experience or where your practice varies from your peers. This in turn allows you to adapt your own learning to fill knowledge gaps or make up for areas you have little exposure to, and to modify aspects of your practice or clinical approach accordingly. That makes you a better doctor right now, as well as placing you in a better position to attempt your college's fellowship exams.

The ability to reflect on practice is an attribute of the competent GP. Reflection on your ReCEnT report, especially when facilitated by your supervisor or Medical Educator, is an opportunity to develop and refine this skill.

Reflection on your ReCEnT feedback report is also a chance to practice your critical evaluation skills – was this a typical week? If not, how will that have affected your results? Are your results on any parameter different to your peers? If so, why is that? Is it due to the patient profile at your practice? Or due to structural issues at your practice (high workload etc)? Or due to practice styles of your supervisors that you have adopted? Or is it due your personal practice approaches and style? If so, do you need to address them or is it OK?

Remember, the report is intended to prompt a reflective process. It is not a benchmarking exercise or an assessment. It may well be, after reflection, quite OK to be different to your peers on any particular parameter.

4. Why do I have to do it more than once?

Because you grow and change throughout your training and this is one way for you to monitor how effective you have been in areas you wanted to progress. You also change locations while training and so your patient group and the clinical experiences you have vary as well. ReCEnT characterises these things very clearly and being able to compare your data from different practices can inform your choice for the next practice.

5. How long does it take to complete ReCEnT?

Once you are familiar with the format (this takes a few consultations in your Term 1 round of data collection) you can complete a typical consultation in less than 2 minutes. Occasional consultations may be more complex and require more information to be recorded and may take a little longer (for most consults only a fairly limited amount of the ReCEnT form is applicable and needs information to be recorded). But it is important to take this little extra time in longer consults as this is important information, capturing the complexity of these occasional challenging consults. The demonstration of completing the ReCEnT data collection by Andrew Davey demonstrates how long a couple of consultations (simple and very complex examples) take to record.

It is essential that you record your information contemporaneously (for accuracy). It is also faster to record the data at the end of each consultation (after the patient has left) while you still have their file open, rather than to leave it to the end of a session when you will have to go back and access each patient's file again.

Many registrars found that making one appointment unavailable per session provides enough time to make up for recording data without adding extra stress to your day. If you elect to do this it must be with the approval of your supervisor and practice manager. Your practice manager should be familiar with this strategy as we advise them when ReCEnT will be operating in their practice and suggest that blocking off an appointment per session is a common approach.

6. Why can't the ReCEnT data be extracted from the practice software?

We agree this would be ideal, but the diverse nature of practice software makes this idea costly and impractical. Also, practice software does not capture some of the important information that we elicit in ReCEnT – for example, generating learning goals, seeking advice and information, and deprescribing.

We have tried to minimise the amount you need to type but we welcome any suggestions for improvement.

7. Why is the form so 'busy'?

We have reduced the data being recorded from the early days of ReCEnT in response to previous feedback. Almost all the data on the form is used in your personalised report. The main exception to this is the 'Antibiotic' question section that reflects new areas of interest in general practice. While there are a large number of sections on the form, in most consultations most of these will not need to be completed as they don't apply very often.

8. Why do I have to do 60 encounters?

The BEACH (Bettering the Evaluation And Care of Health) study of general practitioners in Australia was used as an example when designing many of the aspects of the ReCEnT project, as was the National Ambulatory Medical Care Survey (NAMCS) in the United States. The GPs in the BEACH study record 100 consecutive consultations. In NAMCS, each doctor records a week's consultations. We felt one week of registrar consultations would be an appropriate sample for each registrar. Registrars see, on average, a few more than 60 consultations per week. Thus, we set the sample at 60 consecutive consultations.

9. Why don't you include other forms of management on the forms (guidance, reassurance, advice, exercise, diet)?

While these are undoubtedly important forms of management, they are not easy to characterise as data that can be classified and analysed in a meaningful way. For example, one practitioner may briefly or glibly mention improving diet in wrapping up a consultation (e.g. 'you need to watch your diet') while another may have spent 15 minutes discussing diet in detail with their patient. These clearly are not the same thing but could feasibly be recorded as 'dietary advice' thus implying the two consultations were similar when they weren't. To characterise the data more accurately would be too great a burden on you. Consequently, these sorts of management actions, that are not simple to define and record, were not included in ReCEnT.

10. What encounters should I exclude from recording?

The data you record is used by you to reflect on your practice, so it is intended to capture the variety of presentations that you see. So, don't record things from single-purpose clinics or sessions or designated portions of sessions where you do the same thing for each patient – for example, Immunisation clinics or Cervical screening clinics or INR clinics. This data would be of considerable value from a research point of view, but would not be of utility to you in reflecting on your practice (and ReCEnT is first and foremost an education project).

Also, it is about what you see in your practice office so don't record home visits, nursing home visits or patients you see in the hospital or emergency department. While this means that we don't capture all the richness of some registrars' practice experience, the practicalities of recording data in these settings can be difficult and to ensure consistent data collection we have elected not to include them. This also means your data will be from a comparable context to that of your peers (and the one where you do the most work!) and so you will be able to make better comparisons when reviewing your data. Again, use critical evaluation skills to interpret the numbers: for example, your ReCEnT data suggests you may have seen less older patients than most of your peers, but you are confident that you have still had sufficient exposure to geriatric medicine in your current term via your fortnightly morning session at a local nursing home, so there is no problem.

11. I work at more than one practice, what do I do?

Record data for ReCEnT from the practice where you do most of your sessions. If your sessions are evenly split across practices you will be advised which practice to record your consultations from.

If you work for the Australian Defence Force as well, do not record data from your ADF consultations because they do not represent community general practice which is what your ReCEnT data is compared against.

12. In the 'follow-up' section why isn't there an option for 'appointment with GP as required'?

This section is intended to record when you think a patient must be followed-up and so a *definite arrangement* is made. 'Follow-up as required' (or 'safety-netting') is something that could apply to almost all consultations and so is not informative data for you.

13. Why is there only room for 4 problems?

In prior analyses, the great majority of consultations have 3 or less problems. Consequently, to balance space on the form (when ReCEnT was paper-based) and time spent recording data by you, on the one hand, against the amount of useful data collection, on the other, it was decided that 4 problems was sufficient to provide an accurate sample of your practice. If you deal with more than 4 problems, then pick what you think are the most important four to record.

14. Can you clarify what you mean by 'seen by you for this problem/s ever before' e.g. I have seen the patient before for an URTI but not for this URTI, how do I answer?

This part of the encounter form refers to the problem you are seeing in the encounter today. So, in the case above you have not seen the patient before for this particular URTI therefore the answer is 'no'.

However, if you have a patient who you have seen before for care of their COPD (e.g. prescription renewal) and today they present with an exacerbation of their COPD then this is a problem you have seen before (it is another aspect of their COPD) and so the answer is 'yes'. But, if today is the first time you have ever seen them for their COPD then the answer is 'no'. This is because this question is concerned with **continuity of care** – we want to know that you are getting experience of caring for all aspects of this patient's COPD.

15. What does it mean by 'new' or 'old' problem?

This term is relative to the **patient**, not you.

So, if this is the first time the patient has ever presented with this problem then it is 'new'. If this is the first time you have seen the patient for this problem, but it is one they already knew about (i.e. it is not a new diagnosis to the patient), then it is 'old'.

The interpretation is quite different to 'seen by you for this problem/s ever before' (previous FAQ, above). For this question, a new episode, for example the first time the patient presents with a new acute infective exacerbation of COPD, *is deemed a new problem*. Even if they have been seen in the past for their stable COPD, and even if they have been seen for *previous* infective exacerbations of their COPD.

16. What constitutes de-prescribing?

De-prescribing means you have purposively ceased a medication for a particular problem. Thus, if a patient developed a cough on ramipril and you ceased the ramipril you would:

- record Ramipril as de-prescribed and record the reason for de-prescribing as 'side effects'

If you were reviewing a patient's medicines regimen and decided that their omeprazole, originally prescribed for gastro-esophageal reflux, was, on balance, no longer indicated, and you ceased it, you would:

- record omeprazole as de-prescribed and record the reason as 'no longer indicated'

If you were reviewing a patient's clinical state and their medicines regimen and decided that their sertraline was not improving their depression, and ceased it, you would:

- record sertraline as de-prescribed and record the reason as 'lack of efficacy'

We also want you to record medications that you intend to cease in the future, but you are weaning so you reduce the dose at this consultation (this has its own section on the encounter form).

BUT

We DO NOT want you to record reduced doses for a medication *if you do not intend to cease it in the future*. When titrating the dose of a medication we do NOT want you to record one dose of tablet as being de-prescribed e.g. if you changed the dose of ramipril from 10mg tablets to 5mg tablets, we DO NOT want you to record the 10mg dose tablet as de-prescribed.

17. Are OTC (over the counter) medications included in Medications prescribed?

Yes, they are. If you recommend OTC medications, record them.

18. Why are we collecting at this time in the term?

We choose the approximate mid-point of the term (or as close as we can get, logistics considered) to allow time for you to settle into your new practice and for your patient load to have stabilised. This gives the best chance to achieve a representative sample of your practice. Also, for you lucky registrars who are studying for exams it is timed to try and pick a lower point (relatively speaking!) in the cycle of exam stress, after the AKT and KFP and before the OSCE.

19. Do I need to obtain patient consent for ReCEnT?

You **do not** need to obtain your patient's consent to record data.

There are two aspects to ReCEnT - educational and research:

- Educational: you are recording data on your experiences for educational reflective purposes (a sophisticated version of the logbooks kept in most medical training programs). This is a required component of your training and is a powerful tool for you to map your progress, identify gaps in your clinical exposure and plan for future training terms.
- Research: if ***you*** provide your consent, then your de-identified data is added to the research database and analysed to answer questions related to Australian GP education and training generally (rather than for your personal education). Two points should be made about this:
  - You (and your registrar colleagues) are the participants in this study. ReCEnT is a cohort study of registrars – we follow you and your clinical experiences for three terms. As such, you may elect to provide consent for the data you collect on your consultations for educational purposes to also be used for research purposes. This is entirely voluntary. If you elect not to consent to having your data used for research, it will not influence or prejudice your relationship with your Regional Training Organisation. You may also elect to withdraw your consent for use of your data for research purposes at any time (even if you have previously consented to participation).
  - Your patients are not the participants in the study. As such you do not need to obtain patient consent. You do not need to discuss ReCEnT with your patients. You do not need to record anything relating to ReCEnT in the patient record.

The study has been approved by, and is monitored by, RACGP National Research and Evaluation Ethics Committee (NREEC-23-0000000161).

20. What are the ethical implications of a project that is required for your training but collects data that can be used for both educational and research purposes?

Your training organisation requires you to collect de-identified data about your consultations for your own education and reflection. This is facilitated by the personalised report that analyses your data for you to reflect upon on your own, with your supervisor, and with your medical educator. Since this is for your own personal educational use it does not constitute human research, therefore it does not require approval from an ethics committee for you to collect the data.

However, for your ReCEnT data to be used for research purposes then you, as the participant in the study, need to provide informed consent for this. Consequently, this use of your data does constitute human research and is approved and monitored by the RACGP National Research and Evaluation Ethics Committee (NREEC-23-0000000161). If you don't consent, then your data is excluded from the research activity of the ReCEnT project (e.g. data analysis, publications in medical journals, conference presentations, etc). Also, if after your original decision you change your mind, then you can withdraw your consent at any time.

21. Am I able to excuse myself from doing the ReCEnT project?

The ReCEnT collection and reflection processes are a compulsory RACGP education requirement for quality improvement and are designed for you to reflect on your clinical practice and educational approach. Quality improvement is a feature of both the RACGP (Domain 4: professional and ethical role) and ACRRM (Domain 7 – Practise medicine within an ethical, intellectual, and professional framework) curricula and are important skills to acquire and practice.

Reflection on practice is also an essential attribute of the competent clinician. Like all clinical skills it requires training and practice. Learning how to reflect on practice, including reflection aided by ReCEnT data, involves learning how to interpret and understand personal practice data, and acting upon it if appropriate. This will be aided by guidance from your supervisor and ME, and we urge you to involve them.

ReCEnT is also a research project and the data that is collected has, and continues to be, used in a number of ways to inform general practice education and training.

You may opt out of the research component of ReCEnT at any time (as per point 19, above). If you wish to opt out of the research component of ReCEnT, contact the ReCEnT team on recentonline@racgp.org.au.

We understand that sometimes registrars may have difficulty completing their ReCEnT collection when unforeseen or exceptional circumstances arise. If this is the case, the ReCEnT team are happy to discuss arranging the collection at a different time. If you require an exemption from doing ReCEnT for a round due to your personal circumstances, please discuss this with your medical educator. Your medical educator will be able to assess your situation and determine if an exemption to the education and training requirement is appropriate.

22. How does ReCEnT contribute to assessment?

Assessment is a broad concept and doesn't necessarily entail grading or classification – or implications for progression in training. ReCEnT is a quality improvement process which helps registrars to identify demographics, presentations, and other key general practice activities in comparison to themselves, peers and established GPs. This information may, when considered in context, help identify gaps, competencies or learning needs that will be required at fellowship. This enables registrars to make an informed choice about future placements or discuss other ways of improving with their medical educator. There is no 'pass mark' attached to ReCEnT. ***It is a 'reflective' not a 'benchmarking' exercise.*** Although comparisons to other registrars' data is provided, there is no measure of 'good' or 'bad' practice in the ReCEnT results – just information on your practice on which you should reflect, taking into account the particular context and circumstances of your patients and your practice. Although there is no grading or pass/fail in ReCEnT, each round needs to be completed.