Teaching and learning in rural general practice

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In 1981 I established a solo general practice in Woolgoolga on the New South Wales mid-north coast. By 1987 the practice had grown to include an associate and a part time assistant. The local population was also rapidly expanding as people from the cities began to undertake their own 'sea change'. The Royal Australian College of General Practitioners' (RACGP) Family Medicine Program (FMP) (later 'the Training Program') was at that time looking for new training practices, so after learning what was involved, I signed up. Since 1988, 28 general practice registrars have trained in Woolgoolga.

Initially general practice terms were of 3 months duration, and only two terms were required. Mentorship time was a loose concept and the RACGP Fellowship exam was optional. There was no specific rural pathway. The placement of FMP trainees into rural and regional areas depended mainly on the persuasive abilities of key staff in state FMP offices (or the desire of a young doctor to undertake general practice training in a rural/regional area).

An informal network of GP supervisors evolved over time in our region (a very collegial activity of practical benefit). We caught up at teacher training workshops in the city once a year and occasionally at local medical events. It is interesting to note just how many of those familiar faces were closely involved when divisions of general practice were being formed in 1993.

General practice training on the New South Wales north coast was regionalised long before the concept became de rigeur, certainly years before GPET was formed and training removed from the RACGP. That history of achievement is now being successfully tapped by North Coast GP Training Ltd, the new regional training provider for the New South Wales north coast.

Throughout the 1990s the process of training for general practice in Australia became increasingly formalised. Basic and advanced terms were increased from 3–6 months each. Mentorship (subsequent) time became standard. Thus, the period spent in general practice under supervision increased from a minimum of 6 months to the now standard 2 year period, or 18 months if special skills are undertaken.

Every general practice is unique. The blend of GP and staff personalities, practice structures, local facilities, and population mix, produce a training environment that cannot be duplicated elsewhere. Some features such as curriculum, paperwork, statutory requirements, and referral processes are necessarily standardised. Some educational techniques are also relatively uniform. For example, most GP supervisors of long standing will readily recall being encouraged to apply 'Pendleton's rules of feedback'. Put simply, it entails finding something positive to say about the registrar's performance before identifying areas of practice that might be performed differently to the benefit of the patient.

Over time, different supervisors become adept at teaching in certain ways. Personal reflection on one's own style and methods remains a very important activity for all supervisors. The presence of other GP supervisors in a practice is of major importance. They all have their own areas of strength in terms of teaching, not to mention heightened clinical abilities in their own areas of interest. The registrar who is able to tap into the collective wisdom and abilities of all GPs at a practice has a major advantage.

A balance between formal and informal teaching in general practice is fundamental. The early stages of a basic term require more intensive activity on the part of supervisors. The new 'apprentices' have begun an enculturation process into general practice. They are also learning a very different context of human health and disease management and prevention from what they have seen in large teaching hospitals. Clerical tasks such as pathology and radiology referrals, scripts and specialist referrals – which experienced GPs perform without much higher order thinking – have to be learnt step-by-step.

Almost all registrar placements in rural and regional Australia involve a major disruption to the life of the registrar and his/her immediate family. Not all partners of registrars have transportable careers. Some will have children who are already established in schools. Some will be from particular ethnic backgrounds whose support systems are largely confined to capital cities. Registrars will leave some or all of their support networks behind. They have to rapidly form new alliances from which to gain emotional as well as educational support. Failure to do this undermines their progress through the term. Supervisors and their staff become an integral part of the new support network for each registrar and involvement of registrars in the social life of the practice and the community is essential.

In May 2004, my practice comprises: one full time principal, two women assistants (working 6 and 3 sessions per week respectively), one full time registrar (who undertook an advanced term in the latter half of 2003 and stayed on for his 'subsequent time'), a full time registrar currently in his basic term, and a further part time registrar who is nearing the end of her 'subsequent time'.

The main teaching activity is the weekly meeting. Each registrar brings cases that have raised unresolved issues for them. These are discussed collectively. Sometimes a specific

knowledge gap is identified and a way to close it suggested. Sometimes a simple affirmation of what was done is all that is needed. News of recent medical advances, changes to the Pharmaceutical Benefits Scheme and Medical Benefits Schedule, or changes in the local medical and paramedical workforces is shared in this forum.

The interaction between registrars is usually very supportive and a very effective teaching tool. Registrars in 'subsequent time' can be a great inspiration to their less experienced colleagues. They also have tremendous credibility in the eyes of the increasing numbers of medical students who are appearing all over regional Australia.

Of great importance to registrars is the ability to obtain advice about an individual patient while the consultation is still progressing. This may be as simple as identifying an appropriate place to which the patient can be referred. It often involves looking at a skin rash or lesion and reassuring both registrar and patient of its benign nature. Sometimes it involves listening to the patient's history and throwing in a few diagnostic thoughts. At other times it is sufficient to reassure that nothing serious is going on with the patient.

Another teaching method is to conduct joint house calls. These are typically to an agreeable long term patient of the practice, relatively house bound, who lives within walking distance of the surgery. Such calls can be made at any lunchtime when other patient commitments permit. Medical students join in at times. Most patients seem to be flattered by the extra attention, particularly those leading lonely lives.

The exercise involved in performing such ambulatory house calls is a useful reviver for the middle portion of the day. The journey allows for the pointing out of various local landmarks and the homes of other patients whom the registrars may one day be visiting. A suitable method of conducting a 'kerbside consultation' can also be imparted to registrars on these forays.

Joint consultations between supervisor and registrar are an important means of providing the required teaching time, especially in the basic term. Typically these involve observation of the supervisor by the registrar, although the roles can be easily reversed. Such joint activities do not need to be confined to the surgery. They can just as readily be performed in the community, at home visits and during hospital rounds or visits to aged care facilities.

Corridor chats are a daily event. If time permits and the registrar's door is open I try to pop in and ask how their day is going. This usually leads to discussion about a particular patient, so it must be meeting an educational or professional need of some type. Opportunities to debrief at an early stage after stressful patient encounters are created wherever possible. Multiple interactions during the course of the day create further opportunities for ad hoc teaching.

Other supervisors within the practice can play formal and informal roles. Women GPs are generally much better placed to impart knowledge of women's health to registrars, and can specifically guide them through the skills of the Pap test when it has not yet been mastered. They will also have other specific areas of expertise that can be the basis for teaching activities.

Our registrars come from a variety of backgrounds. They also have different preferences with regard to learning. Some prefer to do most things on their own, only pausing to seek advice on specific aspects of a patient's diagnosis or management. Others welcome the opportunity to sit in and observe one of their supervisors. All participate regularly in division sponsored educational seminars. All are working toward the FRACGP examination as the demonstrable endpoint of their training. No one has been very keen on learning plans and such things, although we periodically list skills and experiences which they identify as lacking in their repertoires, and attempt to address their specific learning needs as identified.

Being a GP supervisor is a very rewarding activity. It provides regular reason to maintain one's knowledge base. It represents part of our own succession planning as registrars are those who will take over from us when we have had enough. Finally, it represents an opportunity to repay our own debt to those who guided our own faltering first steps in general practice.

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Conflict of interest: none.

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