A teaching ward round in infectious diseases

A pilot module

The ongoing care of patients requires close communication between general practitioners and hospital specialists. In 2005, the General Practice Liaison Office and Department of Infectious Diseases at The Canberra Hospital designed a pilot module to promote interaction between GPs and hospital specialists and to provide an educational opportunity for GPs to be updated on the hospital practice of managing infectious diseases. The simplicity of the module is the key to its generalisability outside Canberra and Australia.

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The Canberra Hospital (TCH) is the principal teaching hospital in the Australian Capital Territory (ACT) and serves a population of around 500 000. The hospital employs four infectious diseases (ID) physicians who provide an inpatient, outpatient and consultative service to the region. Because the care of patients is constantly passing from general practice to the hospital system and vice versa, it is vital to have a good level of communication and understanding between these physicians and the general practitioners in the community. Medications are started, others are stopped, new diagnoses are made and old ones are questioned. Without good communication between GPs and doctors in the hospital system, important information can be overlooked – at the patient's expense. With this in mind, the General Practice Liaison Office and ID physicians at TCH designed a module that would provide a learning experience for GPs and simultaneously familiarise them with the hospital system and its staff.

Objectives

The objectives of the module were to get GPs to:

- meet with ID consultants, junior doctors and medical students
- participate in clinical and radiological meetings with specialists and other members of the multidisciplinary team, and
- join the ID ward round to be updated on management of infectious diseases within the hospital and discuss some of the issues GPs face in managing patients with infections posthospitalisation.

Methods

The pilot module was run over a 3 month period. Every Thursday, one or two GPs attended TCH for 6 hours and participated in the following: a 1 hour ID presentation, followed by a 30 minute radiology meeting, ending with a ward round of ID inpatients and consultations. The Royal Australian College of General Practitioners (RACGP) approved the module as a Category one activity eligible for continuing professional development (CPD) points.

Recruitment of GPs

Fourteen GPs who had previously participated in other educational programs were invited to attend the session. Incentives included parking permits at the hospital for the day on which they participated, and lunch on arrival (this was in recognition that the GPs were coming straight from their morning clinics). Learning objectives were sent to the GPs before the session. The GPs were then orientated at the liaison unit of the hospital before starting the afternoon session. The GPs were later invited to provide feedback on the module with a survey.

The instrument

The instrument was a one page survey consisting of seven questions, including two statements assessed by a Likert scale and five open-ended questions.

Results

The education module

Nine GPs accepted the invitation to attend; two other GPs, who had heard of the module through colleagues,

expressed their interest and were included in the module.

Feedback from the survey

The salient features from the survey were that all GPs felt that the education module had met its stated objectives and their own expectations (either a rating of 4/5 or 5/5). General practitioners were asked about the key learning that they had acquired from the education module and how it would help them in their day-to-day practice. The responses included learning about specific infections, antibiotic choice, good interaction with ID physicians, seeing a meningococcal rash for the first time, and an increased awareness of the risks of hospitalisation from nosocomial resistant bacteria. Suggestions to improve the module included the presentation of an infectious diseases case in the general practice setting. Ten out of the 11 GPs (91%) indicated they would be interested in attending similar modules in other clinical areas; the remaining GP was unsure because of time constraints.

Discussion

Many strategies have been used to improve the integration between hospital and general practice. These have included GPs attending outpatient obstetric clinics, a 2 week clinical attachment for GPs in a hospital unit,[1] and sending hospital clinical bulletins to GPs.[2] However, we are unaware of any published description of a module similar to the one presented here. The design of the current module is simple; after the initial design phase there was no need for preparation on the part of the clinician and requires minimal maintenance. There has been little or no disruption to the ward round routine.

The Infectious Diseases Module appears to have been a success at a number of levels. First, the duration and structure of the module allowed GPs to earn CPD points as part of their continuing education program with the RACGP. Second, it provided GPs with bedside teaching about infectious diseases, which can't be conveyed in a didactic lecture. For example, the GP who was excited to see a patient with the meningococcal rash would almost certainly have seen photos of the rash in journals and in presentations. However clearly, there was no substitute for 'real life' experience. Third, one GP remarked how it provided insight into the workings of hospital admission and discharge, which can be a confusing issue for GPs trying to access the hospital system for their patients. One GP who saw a patient with a hospital acquired, resistant bacterial infection during the session was reminded that hospitalisation was not without risk. Furthermore, the module allowed GPs to interact with staff specialists as professional equals.

Finding a happy medium for educational interaction between GPs and specialists is not always easy. It has been found that GPs want to learn information directly related to their practice, whereas specialists prefer to discuss the latest developments in their subspeciality.[3] This was reflected in the survey results, where two suggestions were made to present infectious disease cases in the general practice setting. Marshall[3] discussed three models of teaching: didactic lectures, which were unpopular with GPs; unplanned learning based on referrals, which was often too time consuming for specialists; and interactive sessions, based on clinical cases, to which both GPs and specialists appeared to be agreeable. This last model comes closest to that used at TCH.

The ID physicians also expressed how they learnt from their GP colleagues during the sessions, both with regard to their experiences with managing infections in the community and their knowledge of the community based health system. For example, while cellulitis is the one of the most common reasons for admission under the ID team, most cases are managed by GPs in the community. The module also provided direction with regard to the content of future education programs for GPs. For example, the ID physicians were surprised that two GPs with a combined experience of over 50 years in general practice had never seen a meningococcal rash.

Good communication between representatives of hospital and community medicine is vital, as patients are constantly moving from one system to the other. A survey of GPs from Melbourne (Victoria) found that they were often frustrated and unhappy with the level of hospital communication and were keen to become more involved.[4] In our education module, both ID physicians and GPs thought that meeting face-to-face helped strengthen relationships, making subsequent communication by phone or letter easier. This module allowed medical students, who were on an ID rotation, to benefit from a GP's perspective on ward rounds and meet with GPs – perhaps for the first time.

Of the 11 GPs who attended the sessions, nine had been invited on the basis of participation in previous programs. This may have introduced a selection bias into the pilot module, because one might have expected these GPs to be more enthusiastic about education modules than those GPs who didn't attend other education programs. However, it appears that the module is being enthusiastically received the second time around. A facsimile was sent to all 120 general practices in the ACT. Within 7 days of sending the fax, 19 GPs had registered for the module and a further six had made phone enquiries.

Conclusion

The Infectious Diseases Module appears to have provided two-way education and integration for both ID physicians and GPs. The opportunity for both groups to interact face-to-face can only improve the relationship between the groups. The success of this pilot module may provide the impetus for the creation of similar sessions with other units at the TCH. While hospitals may say that GPs are always welcome and important, this module is a tangible way of demonstrating it.

Conflict of interest: none declared.

References

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