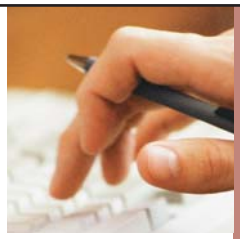

Action research as a learning tool in general practice

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This article is presented to illustrate the power of an effective learning partnership between registrar and supervisor. It is also intended to encourage other registrars to ask questions and publish their results. *Steve Trumble, Editor in Chief*

One of our goals as general practitioners is to improve the quality of delivery of primary health care through continuing professional development. Change in general practice can also be achieved through action research. Although the term 'research' may deter busy GPs, the conduct of action research can be an enriching and not necessarily time consuming process. It can produce rewarding reflections and insights that may lead to better patient outcomes and deeper professional satisfaction.

What is action research?

The definition of action research varies in different settings. The early definition by American psychologist Kurt Lewin included practitioners in a cyclical process of four stages: plan, act, observe and reflect.[1] More recent definitions of action research generally involve three elements: the participatory character of action research, its democratic impulse, and its simultaneous contribution to social science and social change.[2] In essence, it is a style of research rather than a specific method, and is increasingly used in health care settings.

The purpose of action research is to implement change and generate new knowledge.[3] It is often initiated by looking at questions that arise from practice, with a focus on change and improvement. It is a cyclical process of collecting, feeding back and reflecting on data. The extent of practitioner involvement in action research varies from technical/experimental – with researchers having greater control, to emancipatory/empowering – with more emphasis on developing practitioner skills.[1] Action research encourages individual reflection and therefore bridges the divide between theory and practice.

Can action research help promote change in general practice?

Voluntary participation and critical reflection are crucial ingredients of adult learning.[4] Successful learning is most likely to occur when learning is problem based, active and driven by enquiry. Zuber-Skerritt[5] concludes that action research highlights the importance of participants being able to critically reflect on their own practice. The following example of a small scale action research study conducted in our practice demonstrates that change may result from the action research process in individual practitioners and the practice as a whole.

An 'empowering' action research study

Background

A basic term training practice in an outer metropolitan area of Melbourne, Victoria. A registrar reported feeling frustrated and 'used' during some consultations, and 'powerless as a doctor' when patients wouldn't do what was recommended or seemed disinclined to take proposed management strategies seriously. The registrar asked the supervisor: 'Why is this happening?'

In order to discover the answer to this question, the supervisor encouraged the registrar to examine each consultation and ask:

- what did the patient say they wanted
- what did they really want
- what did you give them, and
- how did you feel about the transaction?

The prime learning objectives were to use an action research approach to examine the consultation process; to reflect on the practitioner's feelings about the transaction, to gain further insight regarding patients' 'hidden' agendas, and to learn how to meet real needs voiced – and unvoiced – in the consultation.

Methods

An audit was performed of 50 patients seen by each practitioner (two registrars and two supervisors) during the same week in May 2003. After each consultation, the practitioner recorded comprehensive answers to each of the 4 questions above. Once the data was collected, answers were compared in a learning session and a series of reflective discussions about the findings took place between the registrars and their supervisor.

Limitations

When the audit was initially set up, we had little or no working knowledge of action research. The questions, although developed together, could have benefited from the advice of an experienced researcher. The broad nature of the questions allows us to only present our findings in general terms.

Results

What did the patient say they wanted?

Reasons for presentation fell into two broad categories:

- acute illness, where what patients

Table 1. Types of responses recorded for the question: 'How did you feel about the transaction?'

Positive	Neutral	Negative
Victory	Okay	Awkward
Good	Taking care of business	Perplexed
Satisfied	Objective achieved	Helpless
Happy	Appropriate	Hopeless
Peaceful		Annoyed
Comfortable		Used
Empowered		Anxious
Purposeful		Uneasy
Pleased		

wanted was expeditious explanation and management. This type of consultation was usually straightforward unless the diagnosis was unclear at the time. A subgroup of patients in this category were otherwise healthy young people who presented with a minor illness but in fact had another real, but hidden agenda, and

- chronic and preventive consultations, where routine business was taken care of (eg. repeat scripts, Pap tests, blood pressure checks, certificates, insurance medicals).

What did they really want?

An interesting observation was made as we compared our record of what patients said they wanted versus what they really wanted. Approximately two-thirds of patients seen by each supervisor and one registrar were perceived as having 'hidden' agendas, compared with only one-quarter of patients seen by the other registrar. As we scrutinised the records more closely, the registrar with the lower proportion of hidden agendas had usually recorded more details in the section 'what patients said they wanted'. This registrar had made a deliberate point of allowing the patient to talk freely at the start of the consultation.

What did you give and how did you feel about the transaction?

Analysing the record of our feelings after each consultation was most revealing. The responses are listed in *Table 1*. In general, positive experiences usually occurred when we met the patients' agenda and both parties were mutually satisfied. For instance, we most often felt 'happy', 'good' or 'helpful' when we gave patients what they wanted, such as immunisations, advice, or appropriate management of acute illnesses. We described feeing 'satisfied' or 'pleased' when we gave patients more than they expected, eg. using the consultation opportunistically to promote preventive health.

Negative responses were usually noted when we either couldn't or didn't want to fully meet patients' requests. Sometimes we couldn't meet patients' agendas in one consultation and further steps were required such as referrals and tests. Sometimes we didn't want to meet patients' needs as it was unrealistic or not in their best interests to do so. Other times we recorded negative responses when chronic illnesses had not improved or when there were social problems with no 'quick' solution. Negative responses were also recorded when patients had not adhered to advice previously given, perhaps because it was not aligned with their true agenda.

Neutral responses mostly occurred when routine requests were dealt with, or when acute illnesses presented that were straightforward, with no particularly taxing challenges for the clinician. When patients presented with long lists of problems that were too much to cover in one consultation, the clinician had mixed feelings regarding what was achieved.

Overall, the study made the participating practitioners, especially the registrars, more aware of what goes on during a consultation, both from the patient's and the doctor's perspective. It made us more aware of the circumstances where patients may have a hidden agenda, and how we could help patients to voice their real concerns. As a professional development experience, it taught us that both patient and doctor are more likely to be satisfied with a consultation where agendas are made transparent and dealt with appropriately.

Conclusion

Action research fuses the researcher and the clinician. The empowering reflective process leads to a deeper, multidimensional appreciation of the consultation and the patient-doctor relationship. General practitioners are ideally placed to practise this type of research.

The plan-act-reflect paradigm used in Lewin's definition of action research[1] mirrors the methods used in both active listening and the best adult learning. In the process of doing so, we bring positive change to the way we think about our practice. Our study was not hard science – it is presented here to illustrate the educational usefulness of action research in general practice training. The framework, enhanced by more robust methodology, may prove helpful to other registrars who wish to use action research to solve questions that arise in the course of their learning and work.

Conflict of interest: none declared.

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