General practice registrar observation of their supervisors in consultation

What is the educational value?

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Background

A commonly used learning activity within The Royal Australian College of General Practitioners accredited teaching practices is general practice registrar (GPR) observation of general practitioner supervisor (GPS) consultations. This study aimed to examine the views of GPRs and GPSs on the benefits and limitations of this teaching method.

Methods

In-depth interviews were conducted with eight GPSs and eight GPRs, exploring their experiences of this teaching method and the outcomes achieved.

Results

GPRs reported benefits in orientation, and greater understanding of patient-doctor relationships. However, lack of planning by GPSs limited the potential for learning as goals were rarely set by either party, and there was a reluctance of GPSs to invite formal feedback. The GPSs expressed enthusiasm about their teaching but described little personal benefit from use of this teaching method.

Discussion

While this teaching method was beneficial, it would be more valuable with improved planning, increased time for discussion of consultations, and further training of GPSs in session planning.

Keywords

vocational education/graduate education; education, medical

In Australia, vocational training for general practice through The Royal Australian College of General Practitioners (RACGP) is currently delivered predominantly through 17 regional training providers (RTPs), which oversee all aspects of general practice training.[1] General practice registrars (GPRs) spend 18–24 months training in RACGP accredited general practices, where an accredited general practitioner supervisor (GPS) coordinates and delivers mandated individual teaching. Educational activities are undertaken at the joint discretion of the GPS and GPR. One commonly used teaching method is GPR observation of GPS consultations. The focus of this study was to obtain information on the educational value of this teaching method.

Australian general practice training is underpinned by the application of adult learning models and the principles of experiential, needs focused, purpose driven learning, regular professional reflection, and the provision of quality feedback.[2–4] However, a search of the recent literature (1984–2011) found no information about the value of GPR observation of GPS consultations in the general practice setting, or the application of these principles in its execution.

This article presents the results of semi-structured interviews with GPRs and GPSs within the Victorian Metropolitan Alliance (VMA), an RTP, exploring their experiences of this teaching method and the outcomes achieved. Its benefits and limitations are described, and recommendations for improved educational outcomes discussed.

Methods

To ensure participant anonymity, the principal researcher, an experienced VMA medical educator (ME), requested the coordinators of two VMA training regions outside her area of work to randomly submit names of six GPRs and six GPSs from within their regions, ensuring a range of training level, gender and supervision experience. Twenty-three potential participants received invitations from the VMA Director of Medical Education and Training. Those not declining involvement by return fax were telephoned and invited to participate (*Table 1*).

A detailed interview schedule (*Table 2*) was informed both by the literature and the experience of the principal researcher as a GP and experienced ME.

All interviews were conducted by telephone, audio recorded, de-identified and transcribed. Saturation occurred after 12 interviews, but 17 were completed (eight GPSs, nine GPRs). Data analysis was agreed between two researchers (CL, MT-S) and comprised of identification of themes, key words and phrases relating to the process, value and benefits of GPR observation of GPS consultations. Axial coding then resulted in refinement and linking of themes.

Results

Results for GPR and GPS interviews are presented separately, given that participant interviews were conducted individually rather than as paired GPR/GPS practice colleagues and the themes that emerged were somewhat dissimilar.

GPR experiences

The demographic details of eight GPR participants are described in *Table 3*. Nine GPRs and eight GPSs (total 17) were interviewed, however, one

Table 1. Summary of sampling and recruitment	
Current enrolled VMA GPRs in selected regions	99
Current VMA GPSs in selected regions	62
Letters of invitation mailed	23
Declined participation by fax, reason unknown	2
Declined after telephone contact (personal leave pending)	2
Not contactable by telephone	2
Agreed to interview after telephone contact	17
Participated in interview	17
Recording distorted (GPR)	1
Total completed interviews	16

GPR recording was distorted on the tape and thus not usuable, meaning total analysed was 16.

Seven of the eight GPR participants had observed their GPS consulting either opportunistically, or as an integral component of the in-practice teaching program. However, this is not a compulsory educational activity, and there was one GPR whose supervisor did not include this as part of their teaching. The reasons for sitting-in were rarely discussed beforehand and, for most participants, this teaching activity was undertaken as part of new practice placement orientation with a perceived range of unstated benefits:

> 'It was his plan as part of the training for me and I thought it was good because I got to see somebody more senior and how they go about doing their work.' [GPR 1]

> '… it is useful as an introduction to the patients … and using computers while not trying to exclude the patient … explaining things when there is a new diagnosis …' [GPR 2]

Table 2. Interview schedule
1. Professional background and experience in general practice
2. Experience of observation of GPS consultations (GPR and GPS): aims, reasons, frequency, circumstances, perceived benefits
3. Planning of the session: initiation, structure, content, goal setting
4. Conduct of the session: number and types of patients, booking structure, follow up discussion, provision of feedback
5. Outcomes: positive and negative outcomes, review of learning goals, long term changes in practice for GPR and GPS, future willingness to participate

The GPRs were generally enthusiastic about the process, although this varied according to their clinical experience in general practice:

> 'I love sitting in with other doctors … you do get to see how other people work and how things are done.' [GPR 3]

No GPR reported prior discussion about the setting of specific learning goals; generally this was considered unnecessary. Some indicated their belief that a focus on achieving such goals would detract from the experience:

> 'I do not believe in learning goals.' [GPR 4]

While the structure of sessions varied depending on the GPS, generally patients were booked at the usual 15 minute intervals without any additional time allocated for discussion. Patients were not specifically selected and usual bookings prevailed:

> '… this was purely his afternoon bookings and I just piggy backed on top of it.' [GPR 5]

The degree of GPR involvement in the consultation varied according to the direction given by the GPS, sometimes resulting in boredom:

> 'And so from the observer stand point, unless I am actively involved it becomes quite boring for me.' [GPR 8]

Given the minimal time allocated for review post-consultation, discussion was unstructured and spontaneous. The GPRs were not encouraged to offer specific formal feedback to the GPS on the consultation and many felt daunted at the prospect:

> '[We could ask] any questions we have about the consult.' [GPR 6]

> 'No, I wouldn't have felt comfortable [to have given the GPS feedback on his performance].' [GPR 3]

Despite the unstructured nature of the exercise, GPRs generally described the process as useful, especially when they were able to observe more than one of their GPSs in consultation:

> 'I would sit in and watch how they would use the computer and do the billing and it was good … you could observe different consulting styles, [and] look at things like time management, focused history and focused examination.' [GPR 7]

GPS experiences

Demographic details of eight GPS participants are described in *Table 4*. All the GPS participants involved their GPRs in sitting-in on their consultations, usually as a practice orientation exercise. A strong sense prevailed among the GPSs that GPR observation of an experienced GP at work would give them an understanding of the style and diversity of general practice:

> '… part of [sitting-in] is just orientation because it is really hard to tell them everything when they first start and often they will learn as you are doing it … it also just shows them how we work, how we interact with the patient.' [GPS 1]

The length and frequency of the sessions depended on the stage of training and was individualised by the GPS according to their perceived needs of the GPR. They confirmed the GPR experience that rarely were specific learning goals set, although occasionally a particular focus would be suggested:

> '… most of my teaching is based on what I think is good for that particular registrar or what they want to do.' [GPS 2]

Although some GPS participants were aware of what they wished to achieve, this was not usually discussed with the GPR:

> 'I suppose my thing with registrars is that I am interested in them becoming patient-centred, and I use that session to illustrate what I am on about, what I mean by that, because they don't necessarily know what that means.' [GPS 3]

Some participants believed that the educational value for the GPR was improved by sitting in with different GPSs while consulting:

> '… even though I am the designated GPS, we share the supervising role equally between us. It means that the GPR is

exposed to a variety of different areas of interests and expertise and also different practice styles.' [GPS 1]

The majority of GPSs booked patients as usual every 15 minutes. There was a strong view that observation sessions should reflect the reality and pace of general practice and thus, not be subject to detailed planning. Therefore discussion after the consultation was deliberately unstructured, and focused on whatever aspect was of interest to either party:

'I think it should be just whoever walks in the door because that is the nature of general practice.' [GPS 4]

'At the end of the patient [consultation], it might be really straight forward and I might say, "Anything you want to discuss about that one, any thoughts, comments or queries?" Other times it might be, "Look, I was interested in the fact that you did such and such or I have never heard of that drug". … sometimes during the consultation I might say "Are you familiar with this? Any thoughts about what you might do in this situation?".' [GPS 1]

Table 3. Demographics of GPR participants

Gender	Male Female	3 5
Term	GPT1 GPT2 GPT3/4	2 4 2
Place of graduation	Australia International	6 2
Years since graduation	0–5 >5	4 4
Previous medical experience	Other GP Specialty Nil	0 4 4

Table 4. Demographics of GPS participants

Gender	Male Female	5 3
Years as GP	<10 10–20 >20	1 0 7
Years as GPS	<5 5–10 >10	2 1 5
Years since graduation	<10 >10	0 8
Training level of GPRs	GPT1/2 All levels	2 6

While GPS participants acknowledged that GPR feedback on their consulting was potentially an important teaching tool, most were reluctant to invite it. This option was rarely discussed, because of a perceived power imbalance. However, many invited informal feedback without prior notice:

'I ask them to identify what was well done, what they liked, what they didn't like, what could I have done better. They are not very good at giving feedback but I think it is important that they start to do this, they might be thinking of things in their mind that I could improve on, and that is still good because it means that they are thinking about [this].' [GPS 4]

The GPS participants described positive benefits they believed the experience conferred on the GPR, identifying fewer personal benefits. Few GPSs specifically reviewed the session's usefulness with their GPR at a later time however. Positive outcomes described were:

'The registrars see a lot of the coughs and colds … [now] they get to see what the relationship is like with someone long term … chronic care in action, preventative health and where that all fits in, that is another big benefit.' [GPS 4]

'Um, mm, do I get much out of it? Not really.' [GPS 5]

An unexpected theme that arose was the occurrence of teaching sessions where the GPS and GPR alternated in observing each other consulting. This was enthusiastically embraced by many GPS participants who felt it created a greater sense of collegiality and increased the depth of reflection on patient consultations. Participants strongly believed they could reduce any potential power imbalance by concurrently allowing the GPR to observe their consultations:

'I found that system [of observing each other] works really well because we are both closely involved.' [GPS 6]

Discussion

In this study, GPR observation of GPS consultations was commonly practiced, despite the minimal information in the literature to support its educational value.

In this study, little consistency was demonstrated in frequency, time spent, or scheduling of this teaching activity during the term. There was no requirement for documentation, and as such, it was not possible to ascertain accurately how frequently this teaching method is being used in VMA general practices, which would be useful in assessing its educational value. While GPRs report a range of benefits from the use of this teaching method, the lack of prior planning, brief or no discussion time, absence of specific learning goals, and the limited use of structured feedback detracted from its value as a learning activity.

With the recent increase in the number of GPR and medical student places in Australia, more GPs will be required to undertake teaching. Provision of quality teaching in primary care will remain a high and increasing priority in medical education. If this teaching method is to be used in general practice, our study suggests that it needs to be better structured to provide maximum benefit to the GPR participants, rather than a continuation of the more informal, unplanned approach which is often used by GPSs currently.

As stated, the application of adult learning models is the basis of effective training in Australian general practice, yet many of the approaches undertaken by participants in this study were inconsistent with these principles. Participants not only appeared unfamiliar with these concepts, but showed frequent disdain toward them. This was demonstrated in an almost universal reluctance of GPSs in this study to set specific, mutually agreed learning goals, or to engage in discussion of these issues with their GPR. This may be partly explained by a perceived power imbalance between GPSs and GPRs; an issue that GPSs indicated they were aware of and that needs be addressed, possibly within GPS professional development programs.

If GPRs are to take responsibility for their learning, there needs to be a meaningful GPR-directed interaction between the GPS and GPR about all aspects of this educational activity and adequate time set aside for these discussions

before, during and after the observation session.

One well established principle of adult learning is the importance of feedback from teacher to learner.[5,6] As a requirement of GPR training, observation and feedback on consultations is regularly provided by both GPSs and external clinical teachers. In this study, GPSs showed widespread reluctance to request clear feedback from the observing GPRs, but did invite this through a range of unstructured, relaxed approaches.

This study suggests that both GPRs and GPSs need to be better versed in the principles and practical applications of giving and receiving effective feedback. These skills could be used to mutual benefit in observation of each other's consultations and in interactions with general practice colleagues more widely. Indeed, participants who reported engaging in sessions where the GPS and GPR took turns to observe each other's consultations, found the experience generally more satisfying and the collegiality experienced by both participants was observed to be powerful in enhancing the professional relationship. This model of observation may result in improved learning outcomes for both parties.

Thus, results of this study indicate that to achieve maximum learning outcomes from GPR observation sessions, significant attitudinal shift will be required by both parties. The GPSs will need to be willing to address the aims and goals of these sessions, in dialogue with the GPR, and set aside appropriate time for follow up reflection on the consultations observed. This will require them to dispense with the widely held 'present general practice as it is' approach, and instead embrace a more considered process. Likewise GPRs will need to be encouraged to take on a role of active participant rather than passive observer and be willing to offer basic feedback to the GPS as a reflection on the dynamic of the observed consultations. The reluctance by GPRs to articulate their views on the value of this teaching method is inconsistent with the principles of adult learning, where the learner takes some level of responsibility for their own learning.[2] When this method is being used as an orientation exercise, it is still important that outcomes and aims are addressed with full GPR participation.

Study limitations

Due to time and distance constraints, interviews were conducted by telephone rather than face-to-face, which may have been more appropriate.

The limited nature of the study did not permit interviews of GPSs and GPRs working together in the same practice. While such data may have offered a greater breadth of opinion, participants may have been reluctant to be completely open about their views in that scenario.

Recruitment unexpectedly produced well known and experienced GPSs participants. The study would have been enhanced by the opportunity to interview less experienced GPSs, and also those who choose not to use this model of teaching.

Implications for general practice

General practitioners increasingly will be required to teach GPRs and medical students in Australian general practice and currently there appears to be a looming shortage of GPs willing and able to provide teaching to those placed within their practices. All time honoured teaching methods used therefore require regular review as to their educational value. This study provides new information and suggestions for improvement about one commonly used teaching method.

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References

1. Australian General Practice Training Handbook 2013. Available at www.agpt.com.au [Accessed November 2013].
2. The Royal Australian College of General Practitioners. Available at www.racgp.org.au [Accessed December 2013].
3. Hays R. Teaching and learning in clinical settings. Abingdon, UK: Radcliffe Publishing Ltd, 2006.
4. Gordon J. ABC of learning and teaching in medicine. One to one teaching and feedback. BMJ 2003;326:543–5.
5. Kilminster Jolly BC. Effective supervision in clinical practice settings: a literature review. Med Educ 2000;34:827–40.
6. Boendermaker PM, Schuling J, Meyboom-de Jong BM, Zwierstra RP, Metz JC. What are the characteristics of the competent general practice trainer? Fam Pract 2000;17:547–53.

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