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Avoiding 'consultation interruptus'

A model for the daily supervision and teaching of general practice registrars

Background

In general practice placements, much of the teaching occurs when the supervisor is called into the consulting room by the registrar while the patient is still present. How should this unique learning environment affect on teaching strategies?

Objective

This article analyses the nature of general practice teaching and proposes a different model of teaching in a 'patient-present' environment.

Discussion

General practice registrars are advanced learners who benefit from exploration of clinical reasoning in patient encounters. However, teaching interactions that undermine the patient-registrar relationship will affect the registrar's exposure to continuity of care. In this article, a model for the supervisor to follow when entering the registrar's consulting room while the patient is still present is described. This model emphasises leaving the registrar in control of the consultation and the use of 'thinking aloud' to explore clinical reasoning while at the same time preserving the relationship between registrar and patient.

Keywords

general practice; teaching/methods; education, medical, graduate; vocational education

In contrast, registrars are advanced learners attempting to develop expertise. The focus of teaching and learning shifts to the refinement of clinical reasoning and development of advanced clinical and communication skills. Teaching techniques that enable the learner to explore the uniqueness of each consultation and the thinking behind decisions are more useful.

Teaching primary care is different to teaching other disciplines. BEACH data on Australian general practice consultations indicates that a chronic problem is managed at over half of all general practice encounters.¹ Processes of care such as a request for a health check, certificate or repeat prescription account for more than a third of reasons for the encounter. Therefore, teaching techniques based on analysing a new diagnosis may not be as relevant in primary care.

The importance of ongoing care to the discipline of general practice also makes general practice registrar teaching unique. Registrars should be exposed to chronic disease management, palliative care and antenatal care during their placements.

Teaching techniques that undermine the relationship between registrar and patient, particularly those involving negative feedback, are best avoided as they may reduce the likelihood of the patient returning to see the registrar.²

General practice registrar teaching is also different from other specialty registrar teaching because it usually occurs in private practice. In this setting, patient needs take precedence over learner needs.³ The Royal Australian College of General Practitioners vocational training standards allow for up to two-thirds of registrar teaching to occur outside of set-aside teaching sessions.⁴ Much of this will occur when the registrar calls the supervisor into their consulting room while the patient is still present.

Teaching techniques, which are time efficient while being mindful of the patient are required.

'Consultation interruptus' is an apt description of the day-to-day supervision of general practice registrars – a series of interrupted consultations failing to produce a learning outcome. To avoid this happening, teaching needs to be tailored to the unique features of the general practice learning environment.

This article analyses these features and describes how to plan for 'on the fly' teaching of general practice registrars using the WWW-DOC model (see *Table 2*). The WWW-DOC model avoids undermining the patient-registrar relationship and uses 'thinking aloud' as a teaching strategy.

What's different about general practice registrar teaching?

The medical student teacher focuses on assisting the student to acquire foundation factual knowledge and to utilise a structured approach to clinical situations and employ common rules of practice.

Existing models

Despite these differences between general practice registrar teaching and medical student and other specialty registrar teaching, there are few examples in the literature of tailored approaches to daily general practice registrar teaching, particularly teaching while the patient is present.

Lillich, et al⁵ reported on an active approach to supervising in a community family medicine practice. In the POWER model described, the general practice supervisor actively runs the team – organising, anticipating problems and being more readily available for feedback. This active approach was linked to more rapid throughput of patients and improved clinic efficiency. The study did not look specifically at educational impact, but the increased availability of supervisors might reasonably be expected to have a positive outcome.

Two commonly referenced models for clinical teaching are the One Minute Preceptor⁶ model and the SNAPPS model (Table 1).⁷

Both models appear to focus on new diagnoses making them less applicable in many primary care consultations. If these models are used when the patient is present with the registrar, there is the potential to undermine the patient-registrar relationship. In the One Minute Preceptor model, general rules are taught and errors corrected. In the SNAPPS model, the registrar is encouraged when probing the preceptor to reveal areas of confusion and uncertainty and in the last step is given homework. These models remain useful for teaching sessions when the patient is not present and, in particular, in analysing new presentations.

Planning for teaching while the patient is present

A teaching maxim is that planning improves teaching. At first glance, teaching in the registrar's consulting room while the patient is still present would appear to defy planning. The content of the learning interaction is unpredictable and is driven by the learner and the patient rather than the teacher. Although content cannot be planned, how and when supervision and teaching occurs and the structure of the interaction can and should be determined in advance.

During orientation the supervisor should discuss with the registrar arrangements for seeking help during daily consulting.

Table 1. One Minute Preceptor and SNAPPS: existing models for case based teaching and learning

One minute preceptor	SNAPPS
Summarise the case	Summarise the case
Get a commitment 'What do you think is going on?'	Narrow the differential 'What are the diagnostic possibilities here?'
Probe underlying understanding 'What led you to this conclusion?'	Analyse the differential 'Why is this diagnosis likely/unlikely?'
Reinforce what was done well	Probe the teacher 'What question would you like to ask me?'
Teach general rules	Plan management
Correct errors	Select issue for self directed learning

Questions to be discussed to establish ground rules include:

- Is there a roster detailing who is supervising?
- Is contact to be made by telephone, computer messaging or a knock on the door?
- Is there a different process for urgent versus nonurgent problems?
- What should be done if the supervisor is not immediately available?
- Can allied health staff be contacted to assist?
- Can patients be returned to the waiting room or moved to another room until both doctors are ready?

When calling for help, registrars should be advised to clearly state the question they need answered and where they want the assistance to occur. Are they seeking telephone advice, the supervisor to come into the room with the patient or a discussion in a confidential area without the patient? For example: 'Could you tell me on the phone how I organise open access colonoscopy?' or 'Are you able to come in to my room and provide a second opinion about a rash?'

When the registrar provides a succinct summary in this manner their learning needs are more likely to be met in a time efficient manner.

Planning the structure of the interaction: the WWW-DOC model

The WWW-DOC model (Table 2) was developed by the author to outline an approach to teaching when the supervisor enters the registrar's room while the patient is still present. This model differs from SNAPPS and the One Minute Preceptor in response to the differences in general practice registrar teaching.

Distinctive features of this model include the supervisor being introduced as providing a 'second opinion', the registrar retaining control of

the consultation and the use of 'thinking aloud' as a teaching strategy.

In introducing the supervisor as providing a second opinion, the relationship between supervisor and registrar is explained to the patient as one between colleagues rather than between teacher and learner. The opinion of the supervisor is not portrayed as more significant than the registrar's opinion. The patient-registrar relationship is not undermined. Importantly, the registrar retains control of the consultation. The interaction begins with the registrar's question and is concluded by the registrar. This is not only more effective from a learning perspective but is more time efficient. The patient-registrar relationship is also reinforced.

'Thinking aloud' is a well known teaching strategy.^{8,9} It enables the supervisor to demonstrate and unpack clinical reasoning without openly questioning the registrar. Examples include: 'I was wondering whether further investigations would be worthwhile?' or 'Am I right in thinking you were concerned about ischaemic pain as a cause here?'

Another advantage of using thinking aloud during the discussion phase of the WWW-DOC model is that frequently the patient will feel encouraged to do the same. The patient's underlying concerns are revealed enabling their agenda to be addressed concurrently.

Working with the WWW-DOC model

Thinking aloud is not always an appropriate strategy. If there are concerns about cancer, suicide risk or child abuse, for example, it may not be appropriate to air these thoughts while the patient is present.

If the registrar has a significant knowledge or skill deficit in a particular area it may not be possible to leave the consultation in the hands of the registrar. The supervisor may need to openly teach and to conclude

Table 2. WWW-DOC: a model for 'on the fly' teaching of general practice registrars while the patient is present

Stage	Process
W	Who is present – introductions
W	Why has the supervisor been called in? Except where there are other reasons, such as handover of care, the registrar will explain this to the patient as a 'second opinion' rather than as 'needing help from my boss'
W	What is the problem that needs another opinion? The registrar starts by stating the specific problem needing assistance and then provides the relevant detail. Identifying the issue before outlining the detail enables the supervisor to assist more effectively as well as gaining an understanding of the registrar's problem definition skills
–	A pause for questions – time for the supervisor to ask for more information from patient or registrar as needed
D	Discuss the case using 'thinking aloud' rather than the supervisor questioning the registrar. 'Thinking aloud' is used to share and explore clinical reasoning. For example: 'the absence of tachycardia makes me think pulmonary embolus is unlikely' or 'this doesn't appear to fit any pattern, so I wonder if 'wait and see' might be the best approach' or 'I was thinking of a trial of an inhaled steroid, what do you think of that approach in this situation?'
O	Opportunities for learning – identify issues for later consideration (or there is a standing agreement that all interrupted consultations will be discussed later)
C	Conclusion – the registrar summarises the outcome of the discussions and the supervisor leaves the room for the registrar to conclude the consultation

the consultation with the patient. This is more likely to happen early in the registrar's placement.

Discussing opportunities for learning can also inadvertently undermine the patient-registrar relationship. This needs to be handled carefully. Alternatively, it may be prudent to plan to review all interrupted consultations at a later time when the patient is not present, such as during a teaching session.

Finally, the WWW-DOC model is designed for learning and teaching, rather than patient care. Although it may facilitate uncovering the patient's agenda, the supervisor needs to be mindful that the primary purpose whenever they enter the registrar's consulting room is the care of the patient.

Summary

Daily general practice registrar teaching while the patient is present differs from medical student, or other specialty teaching. Teaching methods should reflect that registrars are advanced learners acquiring expertise in a discipline where diagnosis is often not the focus of the consultation. Teaching should not undermine the patient-registrar relationship otherwise registrars are less likely to experience continuity of care with patients.

Supervisors should plan for daily teaching during registrar orientation by establishing ground rules regarding how daily teaching will occur. The WWW-DOC model, with an emphasis on the supervisor providing a second opinion and the use of thinking aloud, enables time efficient supervision without undermining the patient-registrar relationship.

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