Evaluation of an interpractice visit peer review program for rural Australian general practice registrars

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Changes to the Australian General Practice Training Program occurred in 2001 allowing registrars in small rural communities to undertake all of their training in one practice. A disadvantage of this change was that there was limited exposure for registrars to different types of general practice. An interpractice visit program utilising peer review between registrars was developed to provide this exposure. This article describes rural Australian general practice registrars' views and experiences of a pilot interpractice visit peer review program.

Peer review is considered to be an effective teaching method to deliver continuing medical education (CME).[1,2] Interaction with peers is more likely to influence changes in clinical practice than didactic lectures.[1,3] Continuing medical education utilising peer review practice visits is well rated by practising physicians[4] and general practitioners.[5–8]

Paradoxically, postgraduates have shown reluctance to be involved in peer review, particularly if it is linked to summative assessment.[9,10] Peer review needs to be encouraged to foster life long learning. Medical students and postgraduates have commented on the benefits of peer review in elective teaching sessions.[11–13]

Based on a literature review, it was theorised that an interpractice visit program would be more acceptable to registrars if it was formative in nature.

Method

External clinical teaching (ECT) visits are a core component of Australian postgraduate general practice training.[14] During these visits registrars are directly observed by senior GPs. Existing resources were adapted to develop an interpractice kit suitable for registrar use (*Table 1*).

The kit was pretested and reviewed by medical educators and The Royal Australian College of General Practitioners (RACGP) New South Wales Censor before piloting. Advice was received that formal ethics approval was not necessary as the project constituted an evaluation of a segment of professional training and registrar participation fulfilled a requirement of RACGP training.

Consent was obtained from registrars to evaluate the pilot. Registrars obtained patient consent for their consultations to be observed by a peer. Observing peers obtained consent from the practice supervisor before a visit. The pilot was conducted in two training regions: New England Area Training Services (six registrars) in northwest New South Wales, and North Coast General Practice Training Limited on the north coast of NSW (two registrars). Visits were conducted from early 2003 to July 2005.

Participant registrars were in their senior subsequent general practice term (third year of training). After reviewing the orientation kit, registrars met with a medical educator in a small group (or individually), either face-to-face or by telephone, to clarify issues before visiting a peer.

Discourse analysis of registrar proformas and assignments was used to evaluate the program. In their assignments, registrars were asked to address a series of questions (*Table 2*) designed to explore their views and experiences of an interpractice visit.

Materials were coded for content (including frequency counts of responses) and themes.[15] Themes were generated by collating categories developed during the initial content analysis and cross checking between documents. Initial content and thematic analysis occurred independently between the primary

researcher, who had a supervisory relationship with participating registrars, and a research officer with very limited registrar contact. The primary researcher's findings were compared with those of the research officer to validate results.

Visit proformas were legibly hand written and most reports were typed. No problems were encountered in coding the hand written materials.

Results

Demographics

Eighteen interpractice visits were conducted by six male and two female registrars. Seven registrars undertook two visits, and one undertook four visits to meet project and interpractice visit requirements. Mean age was 40.3 years (range 30–54 years). All registrars worked in rural communities with populations of less than 25 000.

Benefits raised by registrars

All observing registrars found the project was beneficial to their training and a majority (seven) wished to continue this form of learning in their future careers. This is reflected by *Table 3*, comments 3.1–3.3.

Some commented on their peers' positive reaction to being visited and observed (*Table 3*, comments 3.4 and 3.5).

Skills gained during the project included giving feedback, direct observation, different approaches to treatment, and insights into teaching (*Table 3*, comments 3.6–3.8).

Visiting different practices provided observing registrars with exposure to the diversity of rural practice. They commented on gaining insights into remoteness, access to services, delay in presentations, time management, and practice management. This varied according to patient, doctor, and location of practice (*Table 3*, comments 3.9–3.12).

Another theme included the registrars reporting development of self reflective skills (*Table 3*, comments 3.13–3.14).

Furthermore, other registrars gained insights into patient centred care, seeing 'both the patient and doctor's perspective'.

All registrars found the interpractice visit orientation kit adequate. Two registrars suggested this project could be 'improved by involving more registrars in this type of activity'. One suggested it should become a core training module, and one registrar suggested basic registrars should perform interpractice visits on subsequent general practice registrars.

Disadvantages raised by registrars

Cost was mentioned by four registrars as the main disadvantage. This included lost income and travel expenses.

Two registrars reported experiencing difficulty in giving feedback. One registrar found giving feedback 'daunting', although after initial 'nervousness' this improved with time. Another, despite advice to the contrary, became involved in a three way consultation with the patient. As a result, difficulties arose in these interpractice visits, particularly if there was disagreement in the diagnosis and management of the patient between the treating and observing registrar.

Quality monitoring

Registrars and medical educators

Coding the interpractice visits identified other themes related to the monitoring of the quality of the performance of registrars, and the medical education program overall (*Table 4*, comments 4.1–4.3). These comments also indirectly suggest that these registrars had established a means of assessing and critiquing

Table 1. Components of the interpractice kit

- Orientation materials:
  - – articles on interpractice visits[7]
  - – articles on direct observation[15]
  - – frameworks for assessing the process[16] and content[17] of a consultation
  - – frameworks for giving feedback based on Pendleton's rules[18]
- Acknowledgement that participation is voluntary
- Consent guidelines
- A proforma used to:
  - – report on observed consultations
  - – undertake a clinical note audit of four cases during a practice visit
  - – comment on the organisational, structural and teaching arrangements at each practice
- Advice about avoiding three way consultations
- Advice that the project was not linked to assessment (no final assessment page was included due to the literature review identifying some postgraduates are reluctant to grade their peers)

Table 2. Assignment questions/tasks for general practice registrars

- Prepare a report comparing and contrasting your practice with the two others you visit to meet your training requirements
- Discuss benefits and problems you encountered in undertaking an interpractice visit
- Discuss how you found observing your peers
- Were there any difficulties in giving feedback?
- Would you continue to participate in this form of continuing medical education after you complete training?
- Was the orientation kit adequate?
- How could this project be improved?

the process and content of a consultation.[16,17]

Program and practices

The interpractice visit enabled the infrastructure, equipment, organisation, structure and teaching of training practices to be monitored at a time outside of the regular triennial reaccreditation visit (*Table 4*, comments 4.4–4.5).

Some registrars used the interpractice visit as a form of quality assurance, comparing their own present practice with the visited practice and making recommendations on how to improve their own practice (*Table 4*, comment 4.6).

Table 3. Registrar views and experiences

Benefits raised by registrars	
3.1	'Gives you an insight on how other registrars do their consultations. I managed to pick up information and techniques to use in my consultations'
3.2	'I learnt more from the interpractice visit observing than my colleague'
3.3	'I feel it is imperative to have this interaction with colleagues and will do so on an ongoing basis'
Views on being observed	
3.4	'Both registrars were very welcoming when I approached them for visits'
3.5	'The registrars were comfortable during my observation (they are used to ECT visits)'
Skills obtained during visit	
3.6	'This has made me appreciate that there are different ways of consulting patients presenting with many and varied symptoms. There is no right or wrong way of consulting'
3.7	'It gave me some insight into the difficulties of observing peers and delivering feedback'
3.8	'I found it a privilege and both challenging and rewarding to be able to observe my peer and contribute to feedback'
Diversity and differences in practices	
3.9	'Visiting other practices was an excellent experience during my general practice training. Both of the practices I visited were in larger towns (population 8000–25 000) compared to my town with a population of 1500'
3.10	'Both the practices enjoy prompt services from local radiology and pathology services, which is better than my practice'
3.11	'They are on call once a week, which is less than mine (2–3 a week)'
3.12	'Q fever is commonly encountered at this practice, a reflection of its position within a rural community and contact with cattle'
Self reflection	
3.13	'I became more aware of my own strengths and weaknesses'
3.14	'It is interesting to observe different techniques and nuances of practice that sometimes prove to be useful hints, and at other times may challenge or provoke thought about your own practices'

Discussion

This pilot demonstrates that peer interpractice visits were acceptable and beneficial to Australian rural general practice registrars in their final year of training. Contrary to previous literature on peer review in training,[9] this form of teaching was well received by registrars and most wished to continue this form of learning during their future careers. Possible reasons for this finding may include avoiding linking this program to summative assessment, and the fact that many of the registrars were mature students and possibly more receptive to learning by self reflection. The pilot also involved some selection bias as registrars were involved in the pilot only if, in the opinion of their medical educator, they were sufficiently senior to participate.

Registrars involved in this study found the interpractice visits stimulated self reflection. Reflection is an important skill for adult learners to plan ongoing learning[2,16,18,19] and an effective tool to stimulate change in the clinical practice of clinicians.[1,3] Registrars described improving their skills in direct observation and giving feedback by undertaking this pilot. These are useful skills to assist registrars to become clinical teachers in the future.[14,15]

Incidental to the original goals of this project was the finding that this pilot can be used as a form of quality monitoring. Previously, GPs have used interpractice visits to monitor quality in prescribing.[8] This pilot suggests interpractice visits can also be applied to monitoring quality in medical education.

A limitation of this study is that we lack data on the observed registrars' experience during this form of teaching. There are some indirect observations from the observing registrar about positive and negative peer responses to the visits. It was planned for registrars to pair up and conduct interpractice visits on each other to explore this topic. Unfortunately, this did not occur with sufficient frequency.

Postgraduates tend to underrate the performance of themselves and their peers compared to assessments based on direct observation by faculty staff.[20,21] For these reasons and the fact that self reflection and giving feedback requires some experience and maturity, expanding the program to basic (junior) registrars in its present form would be met with some reluctance.

The interpractice program augments other modalities of formative assessment (eg. ECT visits and participation in workshops), providing an insight into registrar performance in the workplace.[22]

There is a need to further evaluate this form of teaching in terms of cost and benefit from the viewpoints of General Practice Education and Training (GPET) and regional training providers.

Conflict of interest: none declared.

Table 4. Quality monitoring

Registrars and medical educators

4.1 'Both the registrars were good in introduction, rapport and communication. Both of them were very good in taking focused history, physical examination, investigation, and explanation to patients. Follow ups were arranged where appropriate'

4.2 'Dr X and I discussed this just after the patient left. For example, was phenoxymethyl penicillin more appropriate for tonsillitis?... After discussion and review in *Therapeutic guidelines* Dr X agreed... and amended the script accordingly'

4.3 'Easier than a real ECT (with a medical educator); I felt more relaxed'

Program and practices

4.4 'All treatment rooms are well set up... updated emergency doctor's bags are available for common use'

4.5 'Town A practices have informal teaching sessions from supervisors and town B has a 2 hour teaching session every week, as well as informal sessions'

Registrar quality assurance

4.6 'Emergency equipment in other surgeries appears to be well equipped (emergency trolley, oxygen, suction) compared to my surgery... There was communication between the receptionist and doctors regarding billing, and I think this computerised communication between consulting doctor and receptionist would lessen unnecessary confusion about billing for patients'

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