Registrar Clinical Encounters in Training (ReCEnT) Project

Interpreting the Registrar Feedback Report – A guide for supervisors and medical educators

Background

Clinical encounters are the core learning activity of general practice training in Australia. Ideally, the content of each registrar's clinical experience should include "common and significant conditions" and be similar to that of established Australian GPs.

However, in real life, the curriculum "walks through the door", and the exposure to different patient demographics and presentations can be highly variable between training practices and from one registrar to another. This can have an impact on the nature and quality of training.

The ReCEnT project aims to document and analyse the nature of the clinical and educational content of general practice registrar consultations. Every GP training term, registrars record details of sixty consecutive consultations. They are then sent a feedback report comparing their de-identified patient encounters to aggregated registrar data and, in some cases, national GP clinical activity data.

Registrars are encouraged to reflect on the information in the report in terms of their clinical exposure, test-ordering practice, prescribing, follow-up and seeking of information. This guide is designed to assist supervisors and medical educators in reviewing the feedback report with the registrar and enhancing their registrar's learning.

Most importantly, we recognise that a registrar's simple reading of the report without reflection will be of very limited value. We encourage you to explore the findings with your registrar and go 'behind the numbers' e.g. by asking about clinical cases, or patterns of practice. It is also important to appreciate that the ability to reflect on practice is an essential skill for GPs in independent practice, and guiding your registrar through interpretation of, and reflection on, their ReCEnT report is a valuable exercise in acquiring these skills.

Using the ReCEnT report is *not* a benchmarking exercise. It is designed to prompt *reflection*. If a registrar's ReCEnT results on any parameter in the report are different to the mean of their peers, this does not mean that the registrar's performance is problematic. Rather, the result should prompt reflection of what might have influenced the result, what it means, and does it need to be addressed in any way.

Such reflection on results in the report should encompass critical appraisal of the results.

Critical appraisal

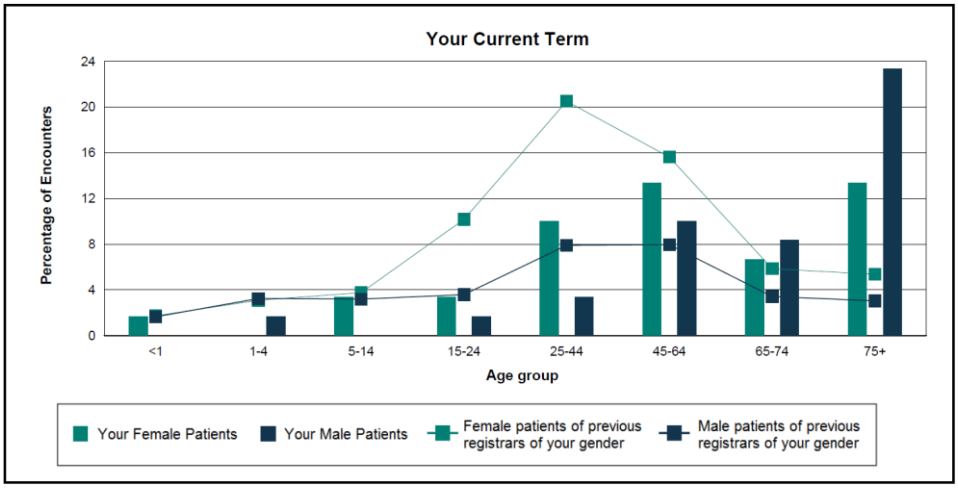
Interpretation of this report requires consideration of a number of factors which may impact upon the results. We therefore encourage the registrar and yourself to critically appraise the results. For example:

- Were the 60 encounters typical of the registrar's usual practice? If not, in what way? How might this have affected the results?
- If the registrar's results were different to those of his/her peers, how much might have been due to the 60 cases being unrepresentative?
- How much might have been due to the practice demographics? How much might have been due to the registrar's personal style or methods of practice?

Specific components of the feedback report

The patients

Looking at the proportion of male and female patients the registrar saw, consider how this compared to their peers (of the same gender). Also see how the mean age compares. Review the graph to see if particular age groups and genders were under or over-represented. How does this compare to your practice demographics, or your own practice? Is there any way of addressing a demographic imbalance in your registrar's experience?



For example, the graph above shows that the registrar was clearly seeing mainly older male patients, and likely to be missing out on a number of clinical problems related to children and women.

Also look at the cumulative data on patient demographics if the registrar is Term 2 or above. Is exposure comprehensive, or is there a deficit in any particular demographic?

Aboriginal/Torres Strait Islander patients

The feedback report identifies the number of patients your registrar saw who were identified as Aboriginal or Torres Strait Islander.

Aboriginal Australians have a substantially greater burden of illness than their non-Aboriginal counterparts. Identifying Indigenous status is an important element of the consultation. This is an opportunity to ask the registrar about their general approach to identifying Indigenous status of patients, the specific patients and presentations, and whether they felt the patient's Indigenous status influenced their management in any way.

Patients with a non-English speaking background (NESB)

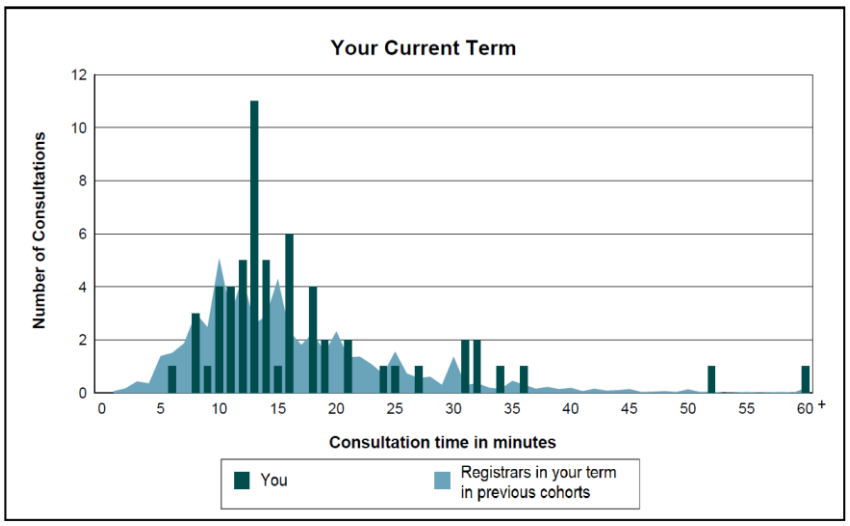
The BEACH program found that one in ten consultations involved a NESB patient. It also found that the demographics and problems presenting by NESB patients differed from English speaking patients. Is the number of consultations with a NESB patient by your registrar typical for the practice or region? This is an opportunity to ask the registrar about their approaches to NESB patients.

This report also records if any consultations were conducted in another language. If the registrar has conducted consultations in another language, carefully consider the number and circumstances of the registrar's non-English language consultations and if this might potentially affect their Fellowship examination preparation (or their preparation for post-training independent practice)

Duration of consultation

The duration of the consultation is an important feature of quality of care in general practice. Longer consultations are associated with a number of factors - higher patient satisfaction, opportunistic preventive care, and identification and management of psychosocial problems. But efficient time management must also be developed during training.

Consider the mean duration of consultation of your registrar compared to their peers, and also the distribution of consultation durations. You might ask about any particularly short or long consultations, and how they feel time management is going.



If the registrar has completed more than one round of data collection, there will be a term-by-term comparison of consultation durations. Ask the registrar about any change in the mean duration of consultation from term to term – does this reflect changes in their capacity for time-management?

Continuity of care

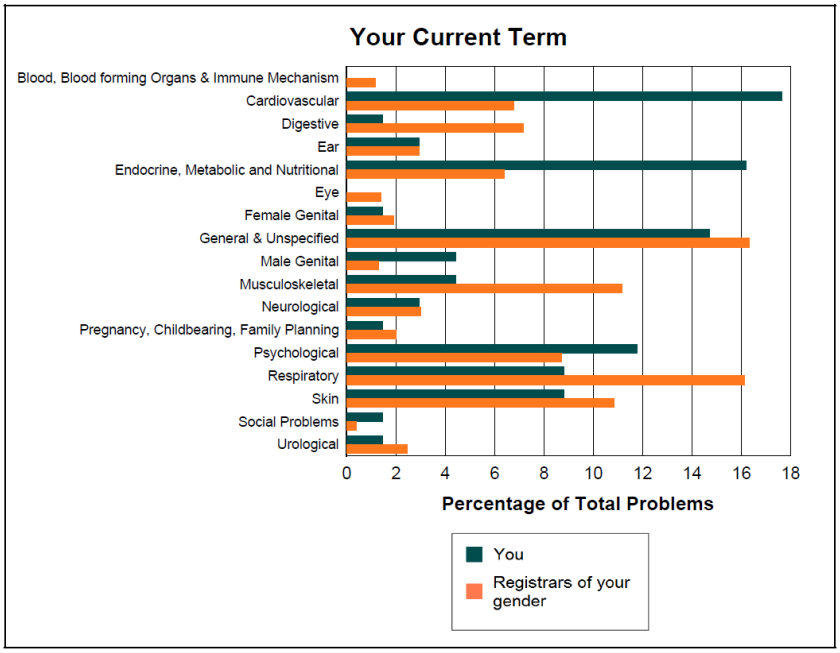
Continuity of care has been found to be closely related to patient and doctor satisfaction. Registrars record whether they have seen the patient before, so called 'upstream continuity'. Compare your registrar's new patient rate with other registrars and your own patients. Is this expected? Do you think it might have any impact on their training?

Registrars also record how often they schedule follow-up for the patient, or 'downstream continuity'. Again, compare this rate with other registrars and with your own practice. You could explore with the registrar how they follow patients up i.e. with themselves or any doctor in the practice.

Problems managed

Problem managed is defined as the 'single most likely provisional diagnosis'. Registrars are asked to record at least one and up to four problems.

Overall, registrars manage about 150 problems per 100 encounters, or about 1.5 problems per consultation on average. This is almost exactly the same as BEACH data. See how many problems your registrar is managing, and the nature of these problems from the graph. Are there any substantial differences from their peers (of the same gender)? Does it relate to the gender and age mix? Is it a surprise? How might the practice address gaps in clinical exposure?



For example, the above graph of problems managed reveals that this particular registrar (the same registrar as the previous graphs) sees almost twice the number of cardiovascular problems (e.g. hypertension, IHD, heart failure.) as his peers. He also has higher rates of endocrine (e.g. diabetes) problems. This would be consistent with older patients with more chronic disease. It might be worth asking how much 'true' management he does, or whether he is just 'baby-sitting' these patients for other doctors in the practice. Again, look at the cumulative data for all previous terms (if available) and discuss any strengths or weaknesses in clinical exposure.

General and unspecified problems

The other 'disease chapter's' names are self-explanatory. The 'General and Unspecified disease chapter encompasses non-specific medical problems e.g. prescriptions, viral illness, medical examinations etc., but also immunisations.

Observations and examinations

It's important that registrars gain experience in conducting physical examinations in the general practice setting and adapting their physical examinations to the general practice consultation context. Did your registrars have adequate opportunity to conduct physical examination?

Top ten problems

Review the top ten problems managed by registrars overall. Does the registrar recall seeing these commonly, and were they comfortable managing them?

Pathology and imaging

Registrars find pathology and imaging test-ordering a challenging area of practice, with some evidence to suggest that tests are often inappropriately ordered. Have a look at the registrar's pathology and imaging test ordering, in particular the proportion of encounters where a test is ordered (in the text), and the rate per 100 encounters (shown in the graphs). How does this compare to their peers, and to BEACH data? If above the mean, does this reflect appropriate test-ordering in the context of older patients with more chronic disease, for example, or does it reflect anxiety and fear of missing serious illness?

Perhaps go back to the problems managed graph and see if this might help explain the rates of test ordering e.g. lots of antenatal patients lead to large numbers of tests ordered, or simple acute illnesses might lead to very few tests. Also, have a look at the top tests ordered by registrars overall and perhaps explore this with the registrar – are they the same common tests, are there difficulties interpreting them etc?

Prescribing

There is also evidence that GP registrars find prescribing complex, and the transition from hospital to community setting difficult. The GP supervisor has been found to play a significant role in influencing registrar prescribing practice.

'Medications prescribed' includes OTC medications as well as prescribed drugs. Have a look at new prescription ordering rates compared to the group. What factors may be influencing prescribing rates of new medications? Again, have a look at the number and nature of problems managed, especially new problems and chronic diseases. Is the registrar simply writing lots of repeat prescriptions, or are they initiating new drugs?

As with tests ordered, have a look at the top ten prescribed medications ordered by registrars overall and discuss their use with the registrar.

Deprescribing

Deprescribing is increasingly being recognized as an area of importance, especially in the management of multi-morbid patients. Polypharmacy is common in these patients and disease-specific clinical guidelines are not equipped to provide assistance with their management. Consequently, identifying potentially inappropriate medicines is an ongoing task for the GP who typically co-ordinates the care of these challenging patients.

Review whether the registrar deprescribed any medications and discuss with them the circumstances if they can recall them, or even use it for a random case analysis to explore the patient's management. Then look at the top ten list of medications de-prescribed by all registrars and consider how these may be relevant to the patient base your registrar is seeing.

Referral

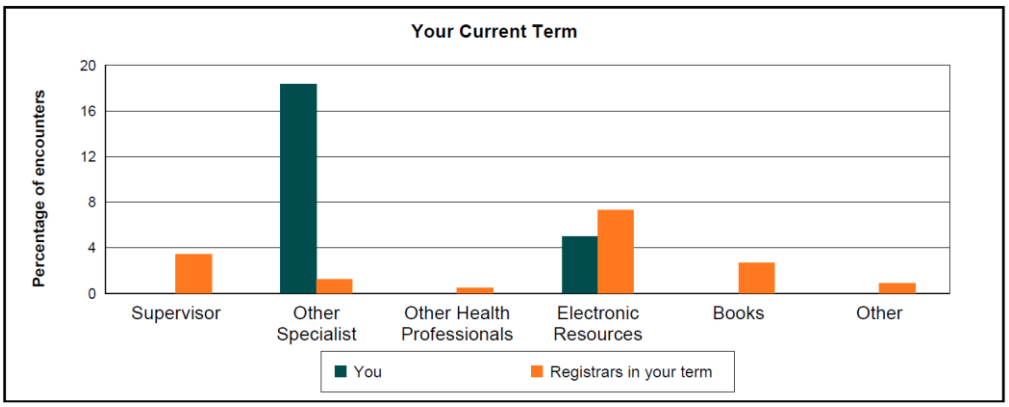
Overall, registrars refer patients to specialists at a rate of ~ 50% more than established GPs. Have a look at the rate of referral for your registrar compared to their peers – remember, numbers here are small and may not be representative of usual practice. This is a good opportunity to explore the registrar's approach to specialist referral.

The feedback report also identifies the number of patients who were referred to hospital. Perhaps ask the registrar about the patient and presentation (and perhaps review the notes) and explore the clinical reasoning around why they were sent to hospital.

Sources of information

Registrars were asked to identify whether they sought information or assistance during the consultation for either diagnosis or management. Overall, registrars access some source of within-consultation information in about one fifth of consultations. The principal sources of in-consultation information are the supervisor and electronic sources. Consulting the supervisor for advice reduces with increasing level of seniority of the registrar.

Consider the rates of information seeking for your registrar. How do they differ from the registrar's peers, and how have they changed over time? Is the registrar accessing electronic resources? Which ones? Are they calling specialists for advice? This is a great opportunity to discuss life-long learning and your own practice around clinical information seeking.



For example, the graph above refers to the registrar whose data has been presented previously. He did not consult his supervisor at all during the recording period, but calls specialists at a much higher rate than his peers. Does this reflect inaccessibility of his supervisor during the data-collection period, a more 'mature' practice by asking specific questions of specialists, or something else?

Review the top sources of information seeking by registrars overall. Are these similar to the sources your registrar reports using? Would you recommend others?

Learning goals

For the purposes of the ReCEnT project, learning goals are defined as 'expected educational outcomes as a result of the clinical encounter'. This does **NOT** include information accessed at the time of the consultation (this should be recorded in **Sources of Information, as above)**. Rather, it refers to plans to look information up or seek advice about following the consultation or at some time in the future.

Does your registrar recall having followed through with researching these learning goals? Did they find the process and the information they obtained useful? Have a look at the registrar's learning goals and also at the top 10 learning goals by all registrars and reflect on any similarities or differences.

Follow up

After reviewing the feedback report, it is useful to make a brief summary of the key findings and a plan for addressing any identified gaps in clinical exposure or other educational needs. These can be reviewed again at the end of term as part of the end-of-term feedback session.

If you have any questions, please contact Parker Magin on 0408 953872 or Parker.Magin@racgp.org.au